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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be delivered for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6308

CERTIFICATE OF DEATH

Reg. Dist. No.

06271
(06271)
211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Grove		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ella Maline Appleby		4. DATE OF DEATH June 30 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 4, 1871
9. AGE (In years last birthday) 85 yn.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME R eubin Kephart		14. MOTHER'S MAIDEN NAME Emeline Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ## (If yes, give year of entry of service) ###		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry Appleby , Germantown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic hypertensive and art.sclerotic h.d. years. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro-vascular accident (10 days) terminal pneumonia 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1955, to June 30 1956, that I last saw the deceased alive on June 29 1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boyer Clinic, Damascus, Md. DATE SIGNED 7/2/56 ACTUAL SIGNATURE Gilcin F. Meadors, Jr. M.D. PHYSICIAN'S NAME (Type) Gilcin F. Meadors, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3 1956	
22c. NAME OF CEMETERY OR CREMATORY Damascus Cent.		22d. LOCATION (City, town, or county) (State) Damascus Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR July 5/56 24b. REGISTRAR'S SIGNATURE Della W. Burdette	

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		Monsieur	
Age		71	
Sex		Male	
Race		White	
Date of Birth		June 10, 1885	
Place of Birth		Leden Grove	
Cause of Death		Hypertension	
Date of Death		June 10, 1956	
Place of Death		Leden Grove	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU A. H.

JUL 9 1956

RECEIVED

July 8 1956

Lutonville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6309

CERTIFICATE OF DEATH

06272

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>31 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> <u>12x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Box 304</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Charles</u> Last <u>Averill</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>November 21, 1941</u>			
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Harold Averill</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Badger</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibro-sarcoma left paraspinal</u> <u>178X</u> DUE TO <u>tissue with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive widespread metastases</u> (c) <u>including lung, retroperitoneal lymph node tract, bone + brain</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>May 31</u> , 19 <u>56</u> , to <u>June 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>July 1, 1956</u>							
ACTUAL SIGNATURE <u>Allan H. Levy</u> M.D. <u>The Clinical Center</u>							
PHYSICIAN'S NAME (Type) <u>Allan H. Levy</u> National Institutes of Health							
Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morning Side Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>The Bois, Peru</u>		_____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barry</u>				ADDRESS <u>Aberdeen Md.</u>			
24a. REC'D BY REGISTRAR <u>DATE</u> <u>5</u> 19 <u>56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06273

6310

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 32 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center, Nat'l. Inst. of Health		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1020 W. Lafayette Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Georgia Davis Bailey		4. DATE OF DEATH Month Day Year June 23 1956	
5. SEX Female	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Nov. 1912
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None -Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Davis		14. MOTHER'S MAIDEN NAME Marion Costely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-22-1293	
17. INFORMANT Medical Record, Clinical Center, NIH, Bethesda 14,		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrabiliary, subcapsular + peritoneal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Focal vascular lesion in the kidney DUE TO (c) Deformity of joints compatible with rheumatoid arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 May , 1956, to 23 June , 1956, that I last saw the deceased alive on 23 June , 1956, and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Roger Black / J.B. Field		M.D.	
PHYSICIAN'S NAME (Type) James B. Field, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 27, 1956		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Field		24a. REC'D BY REGISTRAR DATE JUN 25 1956	
ADDRESS 1631 Druid Hill Ave.		24b. REGISTRAR'S SIGNATURE Mary E. Farrelly	

MMc

BUREAU

1956

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6311 Item 7 Film G207 11-26-56 et
CERTIFICATE OF DEATH

06275

Reg. Dist. No. 2-17

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lehigh Valley Hospital</u>				d. STREET ADDRESS <u>Sandy Spring</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Lo</u> Last <u>Bancroft</u>				4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/27/71</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Moore</u>				14. MOTHER'S MAIDEN NAME <u>Anna Leggett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Hospital Record</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>421.4</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Endocarditis & Myocarditis</u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>56</u> to <u>6/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/25/56</u> , 19 <u> </u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>				DATE SIGNED <u>6/26/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 27 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>				ADDRESS <u>Paytonville Md</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Gertude Blawie</u>	
DATE <u>6-28-56</u>							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 1956
 CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]	
11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]	
13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF NEXT OF KIN [Faint text]	
17. SIGNATURE OF BURIAL OFFICIAL [Faint text]		18. SIGNATURE OF CHURCH OFFICIAL [Faint text]	
19. SIGNATURE OF MINISTER [Faint text]		20. SIGNATURE OF OTHER [Faint text]	
21. SIGNATURE OF OTHER [Faint text]		22. SIGNATURE OF OTHER [Faint text]	
23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]	
27. SIGNATURE OF OTHER [Faint text]		28. SIGNATURE OF OTHER [Faint text]	
29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]	
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57. SIGNATURE OF OTHER [Faint text]		58. SIGNATURE OF OTHER [Faint text]	
59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]	
61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]	
63. SIGNATURE OF OTHER [Faint text]		64. SIGNATURE OF OTHER [Faint text]	
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89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]	
93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]	
95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]	
99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	

RECEIVED
 JUL 2 1956
 BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6312

CERTIFICATE OF DEATH

06276

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hosp				d. STREET ADDRESS Edwax			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First OLIVER Middle LEE Last BARGER				4. DATE OF DEATH Month 6 Day 17 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 10 1895	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Wheaton Paint & Hardware Store		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Henry Barger				14. MOTHER'S MAIDEN NAME Ellen Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-14-2011		17. INFORMANT Address wife, Mrs Myrtle Barger, Edwax, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260.1 (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 12 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 to 6/17 , 19 56 , that I last saw the deceased alive on 6/17 , 19 56 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. H. Ligon				ADDRESS (Street, city or town, state) Sandy Spring, Md DATE SIGNED 6/17/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 6-20-56	
				24b. REGISTRAR'S SIGNATURE Bertine B. Lawler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **216**

06277

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u> c. LENGTH OF STAY IN lb <u>Brookmont - Wash., 16 D. C.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6500 Ridge Drive</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont - Wash., 16 D. C.</u> d. STREET ADDRESS <u>6500 Ridge Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>ODIE</u> Last <u>BARNES</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 8, 1883</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>IBM-Maintenance</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry L. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Florence M. Barnes Item# 2</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 2, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS <u> </u>						24a. REC'D BY REGISTRAR <u>6-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beaie M. Homphrey</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 NEW YORK STATE
 DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 NEW YORK STATE

NAME: BROOKLYN - NEW YORK
 ADDRESS: 22-0000 11th Ave
 CITY: BROOKLYN - NEW YORK

33

10-11-1956

JOHN M. BARRY, JR.

YES

70

BUREAU V.S.

JUN 5 1956

RECEIVED

ROBERT A. BARRY, JR. - BROOKLYN, NEW YORK
 6/5/56
 1st View

6314

CERTIFICATE OF DEATH

Reg. Dist. No. **XX** 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland MASS. b. COUNTY XXXXXXXXXX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Holyoke		d. STREET ADDRESS 30 Lyman Street 132 West Bennett Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Glen Middle Curtis Last BEASLEY		4. DATE OF DEATH Month June Day 9 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Willie D. BEASLEY	
14. MOTHER'S MAIDEN NAME Constance L. GODDU		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Willie D. BEASLEY (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 Congenital Brain Defect DUE TO (b) General Failure of Development DUE TO (c) 1. Bilateral Hare Lip 2. Cleft Palate - large 3. Polydactylism - Upper Extremities		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Enlargement with Congestive Failure		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 June , 19 56 , to 9 June , 19 56 , that I last saw the deceased alive on 9 June , 19 56 , and that death occurred at 3:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. S. Matthews M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 6-11-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far as use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 12 1956

RECEIVED

6281

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Tabernash Park				c. LENGTH OF STAY IN TB 2 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 75 Washington Son & Hosp				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 1332 Holly St. NW			
3. NAME OF DECEASED (Type or print) First Earl Middle — Last Blondheim				4. DATE OF DEATH Month 6 Day 29 Year 1956			
5. SEX M		6. COLOR OR RACE Jewish		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Dept store				10b. KIND OF BUSINESS OR INDUSTRY DC			
11. BIRTHPLACE (State or foreign country) DC				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elias Blondheim				14. MOTHER'S MAIDEN NAME Rosa Spitzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. Hosp Records			
17. INFORMANT Hosp Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Embolism DUE TO 153X Generalized Carcinomatosis DUE TO 1954 Carcinoma of desc Colon DUE TO 1954 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week 1954 1954							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 19-1954 to 6-29-1956 that I last saw the deceased alive on 6-29-1956 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3200-16 St NW, DC DATE SIGNED Benjamin Manchester							
ACTUAL SIGNATURE Benjamin Manchester M.D.							
PHYSICIAN'S NAME (Type) Benjamin Manchester							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF July 1 1956			
22c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Gen				22d. LOCATION (City, town, or county) (State) DC			
23. FUNERAL DIRECTOR'S SIGNATURE B. D. ...				ADDRESS 3501-14 St NW			
24a. REC'D BY REGISTRAR 7/3/56				24b. REGISTRAR'S SIGNATURE J. H. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. J.

1956 9 7.7

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6315

CERTIFICATE OF DEATH

06280

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>47X-3</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>6925 Virginia Ave. NW</i>			
3. NAME OF DECEASED (Type or print) First <i>EMMA</i> Middle <i>D</i> Last <i>Brandes</i>				4. DATE OF DEATH Month <i>June</i> Day <i>9</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1864</i>	9. AGE (In years last birthday) <i>91</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Not Known</i>				14. MOTHER'S MAIDEN NAME <i>Not Known</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Minnie H. Spencer</i> Address <i>Montgomery, D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> 561.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Strangulated inguinal hernia</i> DUE TO (c) <i>left</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of kidney</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 28</i> , 19 <i>56</i> , to <i>June 9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>June 8</i> , 19 <i>56</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Allen J. O'Neill</i> M.D.				ADDRESS (Street, city or town, state) <i>7740 Old Georgetown Rd</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>				Bethesda 14 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6-11-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i> ADDRESS <i>4812 Yacoe Ave NW WASH DC</i>				24a. REC'D BY REGISTRAR <i>DATE 6-14-56</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*
2. SEX: *Male*
3. AGE: *45*
4. DATE OF BIRTH: *Jan 15 1910*
5. PLACE OF BIRTH: *John Doe*
6. OCCUPATION: *Teacher*
7. CAUSE OF DEATH: *Heart Disease*
8. PLACE OF DEATH: *Home*
9. DATE OF DEATH: *Jan 15 1956*
10. TIME OF DEATH: *10:00 AM*
11. SIGNATURE OF PHYSICIAN: *John Doe*
12. SIGNATURE OF REGISTRAR: *John Doe*

BUREAU V. S.

JUN 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6316

06281

CERTIFICATE OF DEATH

Items 8 & 9, Film G200

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Gaithersburg		d. STREET ADDRESS Rt. #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Burton Last Brinegar		4. DATE OF DEATH Month June Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1871
9. AGE (In years last birthday) 75 78 yrs.		IF UNDER 1 YEAR Months 7 Days 13 Hours 13 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsmen		10b. KIND OF BUSINESS OR INDUSTRY SAW - MILL	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Owen Brinegar		14. MOTHER'S MAIDEN NAME Naomi Riggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart disease (c) Arteriosclerosis Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1955 , to June 24, 1956 , that I last saw the deceased alive on June 24, 1956 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. DATE SIGNED ACTUAL SIGNATURE L. I. Leal M.D. L. I. Leal, M. D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26	
22c. NAME OF CEMETERY OR CREMATORY Flower Hill		22d. LOCATION (City, town, or county) (State) Redland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber, Gaytonville		24. REGISTRAR'S SIGNATURE Kertine B. Jones	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
July 1, 1956		Home		Heart Disease	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JUL 2 1956

RECEIVED

General Office of the Registrar
 Boston, Massachusetts

CERTIFICATE OF DEATH

Reg. Dist. No.

216

6317

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7313 Pine Hurst Pkwy.		d. STREET ADDRESS 7981 15th Ave.	
3. NAME OF DECEASED (Type or print) First Donna Middle Louise Last Brooks		4. DATE OF DEATH Month June Day 1 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1955
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert W. Brooks		14. MOTHER'S MAIDEN NAME Janet L. Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Janet L. Brooks		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia from aspiration stomach contents DUE TO Convulsive seizures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Concomitant DUE TO Congenital hypoplasia cerebellum (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 759.3 2 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to June 1 , 19 56 , that I last saw the deceased alive on 29 May , 19 55 , and that death occurred at 5:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Vincent L. O'Donnell		ADDRESS (Street, city or town, state) 8218 Wisconsin Ave Bethesda Md	
PHYSICIAN'S NAME (Type) Vincent L. O'Donnell		DATE SIGNED Beth Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/4/56	22c. NAME OF CEMETERY OR CREMATORY George Washington	22d. LOCATION (City, town, or county) (State) Riggs Rd Md
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home		ADDRESS 5103 Wis. Ave. NW Wash. DC	
24a. REC'D BY REGISTRAR 6/5/56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
JAMES EARL RAY		MALE		35		WHITE		APRIL 4, 1968	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH		10. DATE OF BIRTH	
FEDERAL BUREAU OF INVESTIGATION, WASHINGTON, D.C.		SUICIDE BY FIRE		SUICIDE		MEMPHIS, TENNESSEE		JANUARY 19, 1929	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. NAME OF HOSPITAL		17. NAME OF PHYSICIAN		18. NAME OF CLERK		19. NAME OF REGISTRAR		20. NAME OF WITNESS	
[Name]		[Name]		[Name]		[Name]		[Name]	

BUREAU V. 1

JUN 7 1956

RECEIVED

6318

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural			c. LENGTH OF STAY IN 1b 30 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNMIC,			d. STREET ADDRESS 4709 Bradley Boulevard		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Catherine Middle Rathkamp Last BROWNFIELD			4. DATE OF DEATH Month June Day 18 Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-05	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Rhode Island	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Frederick RATHKAMP			14. MOTHER'S MAIDEN NAME Reigaila BRADY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband CAPT John BROWNFIELD USN RET	
				Same as item #2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rt. fallopian tube DUE TO (c) 18 Mar.		INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 18 May , 19 56 , to 18 June , 19 56 , that I last saw the deceased alive on 18 June , 19 56 , and that death occurred at 6:15A M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Paul P. McBride			ADDRESS (Street, city or town, state) USNH, NNMIC, Bethesda, Maryland		
M.D. USNH, NNMIC, Bethesda, Maryland			DATE SIGNED		
PHYSICIAN'S NAME (Type) Paul P. MC BRIDE LT MC USNR USNH, NNMIC, Bethesda, Maryland					

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 21 June 1956	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6319

CERTIFICATE OF DEATH

06284

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 3 Mt. Airy		d. STREET ADDRESS R.F.D. 3, Mt. Airy	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Angie Middle Idella Last Browning		4. DATE OF DEATH Month June Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1889
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Clarksburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher E. Watkins		14. MOTHER'S MAIDEN NAME Emma Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Address Mr. J. Otis Browning, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO Diabetes Mellitus (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min? 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident...	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 185 , to June 30 , 19 56 , that I last saw the deceased alive on June 30 , 19 56 , and that death occurred at 11:45 P.M. on the causes and on the date stated above.			
ACTUAL SIGNATURE M. McKendree Boyer, M. D.		ADDRESS (Street, city or town, state) Druid Theatre Building July 1, 1956	
PHYSICIAN'S NAME (Type) Damascus, Maryland.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Damascus		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR June 2/56 24b. REGISTRAR'S SIGNATURE Wella K. Burdette	

BUREAU V. 3

9561 5 777

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G200 7-16-56 et

06285

6320

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Albany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOUSE Amelia Buhler</u>				4. DATE OF DEATH Month Day Year <u>6 - 29 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 Mar 69</u>	9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gustave A. Buhler</u>				14. MOTHER'S MAIDEN NAME <u>Margaret R. Stang</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Emilie A Miller Alex. Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma breast</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Metastases</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u> <u>12 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/26/56</u> , 19 <u>56</u> , to <u>6/29/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/26/56</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6/29/56</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				M.D. <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Dr Georges Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S H Hines Co Funeral Home 2901-14 St W</u>				24a. REC'D BY REGISTRAR DATE <u>6-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bertunde B Lowley</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

6321

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 26 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Francis Last Burriss		4. DATE OF DEATH Month June Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/81
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR: Months 7 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Burriss		14. MOTHER'S MAIDEN NAME Elizabeth Gates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Record (Daughter)		Address no	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Arterio Sclerosis 450.0 DUE TO Myocardial Infarction, Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2 weeks DUE TO Amputation, mid thigh 6/22/56 (c) Amputation, mid thigh 6/22/56 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6 19 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no		20f. (City or town) (County) (State) no	
21. I certify that I attended the deceased from 6/11 , 19 56 , to 6/27 , 19 56 that I last saw the deceased alive on 6/27 , 19 56 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sanby Sp... DATE SIGNED 6/28/56 ACTUAL SIGNATURE JWB M.D. J. W. Bird, M. D. PHYSICIAN'S NAME (Type) J. W. Bird, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30/56	
22c. NAME OF CEMETERY OR CREMATORY Salom		22d. LOCATION (City, town, or county) (State) Brookville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barker		24a. REC'D BY REGISTRAR DATE 6-28-56	
24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4331

1. NAME OF DECEASED MURPHY, JAMES		2. SEX Male	
3. AGE 65 years		4. DATE OF BIRTH 1890	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. DATE OF DEATH July 2, 1956	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		14. SIGNATURE OF DECEASED J. H. Smith	
15. SIGNATURE OF FUNERAL HOME J. H. Smith		16. SIGNATURE OF BURIAL PLACE J. H. Smith	
17. SIGNATURE OF CORONER J. H. Smith		18. SIGNATURE OF JURY J. H. Smith	
19. SIGNATURE OF JURY J. H. Smith		20. SIGNATURE OF JURY J. H. Smith	
21. SIGNATURE OF JURY J. H. Smith		22. SIGNATURE OF JURY J. H. Smith	
23. SIGNATURE OF JURY J. H. Smith		24. SIGNATURE OF JURY J. H. Smith	
25. SIGNATURE OF JURY J. H. Smith		26. SIGNATURE OF JURY J. H. Smith	
27. SIGNATURE OF JURY J. H. Smith		28. SIGNATURE OF JURY J. H. Smith	
29. SIGNATURE OF JURY J. H. Smith		30. SIGNATURE OF JURY J. H. Smith	
31. SIGNATURE OF JURY J. H. Smith		32. SIGNATURE OF JURY J. H. Smith	
33. SIGNATURE OF JURY J. H. Smith		34. SIGNATURE OF JURY J. H. Smith	
35. SIGNATURE OF JURY J. H. Smith		36. SIGNATURE OF JURY J. H. Smith	
37. SIGNATURE OF JURY J. H. Smith		38. SIGNATURE OF JURY J. H. Smith	
39. SIGNATURE OF JURY J. H. Smith		40. SIGNATURE OF JURY J. H. Smith	
41. SIGNATURE OF JURY J. H. Smith		42. SIGNATURE OF JURY J. H. Smith	
43. SIGNATURE OF JURY J. H. Smith		44. SIGNATURE OF JURY J. H. Smith	
45. SIGNATURE OF JURY J. H. Smith		46. SIGNATURE OF JURY J. H. Smith	
47. SIGNATURE OF JURY J. H. Smith		48. SIGNATURE OF JURY J. H. Smith	
49. SIGNATURE OF JURY J. H. Smith		50. SIGNATURE OF JURY J. H. Smith	
51. SIGNATURE OF JURY J. H. Smith		52. SIGNATURE OF JURY J. H. Smith	
53. SIGNATURE OF JURY J. H. Smith		54. SIGNATURE OF JURY J. H. Smith	
55. SIGNATURE OF JURY J. H. Smith		56. SIGNATURE OF JURY J. H. Smith	
57. SIGNATURE OF JURY J. H. Smith		58. SIGNATURE OF JURY J. H. Smith	
59. SIGNATURE OF JURY J. H. Smith		60. SIGNATURE OF JURY J. H. Smith	
61. SIGNATURE OF JURY J. H. Smith		62. SIGNATURE OF JURY J. H. Smith	
63. SIGNATURE OF JURY J. H. Smith		64. SIGNATURE OF JURY J. H. Smith	
65. SIGNATURE OF JURY J. H. Smith		66. SIGNATURE OF JURY J. H. Smith	
67. SIGNATURE OF JURY J. H. Smith		68. SIGNATURE OF JURY J. H. Smith	
69. SIGNATURE OF JURY J. H. Smith		70. SIGNATURE OF JURY J. H. Smith	
71. SIGNATURE OF JURY J. H. Smith		72. SIGNATURE OF JURY J. H. Smith	
73. SIGNATURE OF JURY J. H. Smith		74. SIGNATURE OF JURY J. H. Smith	
75. SIGNATURE OF JURY J. H. Smith		76. SIGNATURE OF JURY J. H. Smith	
77. SIGNATURE OF JURY J. H. Smith		78. SIGNATURE OF JURY J. H. Smith	
79. SIGNATURE OF JURY J. H. Smith		80. SIGNATURE OF JURY J. H. Smith	
81. SIGNATURE OF JURY J. H. Smith		82. SIGNATURE OF JURY J. H. Smith	
83. SIGNATURE OF JURY J. H. Smith		84. SIGNATURE OF JURY J. H. Smith	
85. SIGNATURE OF JURY J. H. Smith		86. SIGNATURE OF JURY J. H. Smith	
87. SIGNATURE OF JURY J. H. Smith		88. SIGNATURE OF JURY J. H. Smith	
89. SIGNATURE OF JURY J. H. Smith		90. SIGNATURE OF JURY J. H. Smith	
91. SIGNATURE OF JURY J. H. Smith		92. SIGNATURE OF JURY J. H. Smith	
93. SIGNATURE OF JURY J. H. Smith		94. SIGNATURE OF JURY J. H. Smith	
95. SIGNATURE OF JURY J. H. Smith		96. SIGNATURE OF JURY J. H. Smith	
97. SIGNATURE OF JURY J. H. Smith		98. SIGNATURE OF JURY J. H. Smith	
99. SIGNATURE OF JURY J. H. Smith		100. SIGNATURE OF JURY J. H. Smith	

BUREAU V. 1

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6322

CERTIFICATE OF DEATH

Reg. Dist. No.

06287

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 8800 Chalon Drive	
3. NAME OF DECEASED (Type or print) First Louis Middle Rosenberg Last Caplan		4. DATE OF DEATH Month June Day 18 , Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1915
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Caplan		14. MOTHER'S MAIDEN NAME Lena Rosenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteric Insufficiency DUE TO (c) Rheumatic Ht Disease		INTERVAL BETWEEN ONSET AND DEATH 10 min. 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 56 , to June 18 , 19 56 , that I last saw the deceased alive on June 18 , 19 56 , and that death occurred at 11:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene Braunwald		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/18/1956	
PHYSICIAN'S NAME (Type) Eugene Braunwald, M.D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/56	
22c. NAME OF CEMETERY OR CREMATORY King David Memorial Falls Church, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis + Sons, 3501 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 6-21-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6323

CERTIFICATE OF DEATH

06288

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD</u>		c. LENGTH OF STAY IN 1b <u>12 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS CASHELL</u>		4. DATE OF DEATH Month Day Year <u>JUNE 6 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 9, 1897</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THEODORE CASHELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY WILKERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>IRVING G. CASHELL</u>		Address <u>ACEX, VA 5920 DAWES AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral adrenal hemorrhages</u> DUE TO (b) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital myelomelanoma & cerebral hypoplasia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1956</u> to <u>June 6, 1956</u> , that I last saw the deceased alive on <u>June 4, 1956</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u>		ADDRESS (Street, city or town, state) <u>1919 Seminary Rd, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>		DATE SIGNED <u>June 6, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u>		ADDRESS <u>Rockville Md</u>	
24a. REC'D BY REGISTRAR <u>Ben M Thompson</u>		24b. REGISTRAR'S SIGNATURE <u>Ben M Thompson</u>	
DATE <u>6/8/56</u>			

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUN 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6324

CERTIFICATE OF DEATH

06289

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery-</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>		d. STREET ADDRESS <u>Route 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Mary Cerutti</u>		4. DATE OF DEATH Month Day Year <u>June 27 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. VET. ADM.</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES F. SULLIVAN</u>		14. MOTHER'S MAIDEN NAME <u>Rosina Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Rosina Easter</u>		Address <u>420 Pine Street School Silver Spr. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis + Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Jan. Arteriosclerosis + Senility</u> DUE TO (c) <u>J</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-3</u> , 19 <u>55</u> , to <u>27 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 June 56</u> , 19 <u>56</u> , and that death occurred at <u>3:41 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Basley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>27 June 56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BASLEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor Pk 600 Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chanler Co.</u> ADDRESS <u>Olney, Md.</u>		24a. REC'D BY REGISTRAR <u>6-28-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Lawrence</u>	

RECEIVED
JUL 6 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6325

CERTIFICATE OF DEATH

06290

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		c. LENGTH OF STAY IN 1b <u>15 hrs 19 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>1218 Rockville Pike</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John CLARK</u>		14. MOTHER'S MAIDEN NAME <u>Vera S. COLLINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Father John CLARK RD3 USN</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hyaline membrane dis.</u> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity</u> INTERVAL BETWEEN ONSET AND DEATH <u>1.3 hr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>19</u> p. m. Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>28 June</u> , 19 <u>56</u> , to <u>29 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 June</u> , 19 <u>56</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USNH, NNMCM, Bethesda, Maryland</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>H. A. Pearson</u>		M.D. <u>USNH, NNMCM, Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>H. A. PEARSON LT MC USN</u>		<u>USNH, NNMCM, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5 Jul 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>30 Jun 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Barry L. Russell</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>C&O CANAL, POTOMAC</u>				d. STREET ADDRESS <u>426 WHITESTONE ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>E.</u> Last <u>CLARKE, III</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 27, 1950</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student, Kindergarten</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL E. CLARKE</u>				14. MOTHER'S MAIDEN NAME <u>MARJORIE LITTLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO. 		17. INFORMANT <u>MR. DANIEL E. CLARKE, JR., 426 Whitestone Road</u> <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Drowning</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell into canal while fishing with father</u>			
20c. TIME OF INJURY Hour <u>10:15</u> a. m. Month, Day, Year <u>6-9-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C&O Canal</u>		20f. (City or town) (County) (State) <u>Potomac</u> <u>Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>FRANK J. BROSCART</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>6-11-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, cremation, or removal.

MASSACHUSETTS STATEMENT OF HEALTH - JUNE 1956
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 11 1956

RECEIVED

6282

CERTIFICATE OF DEATH

Reg. Dist. No.

7/13

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Virginia</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hosp.</i>		e. STREET ADDRESS <i>509 Belview Blvd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Rebecca</i> Last <i>Cogar</i>		4. DATE OF DEATH Month <i>6</i> - Day <i>4</i> - Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-1896</i>
9. AGE (In years last birthday) <i>39</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Run Home</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Skidmore</i>		14. MOTHER'S MAIDEN NAME <i>Mary Townsend</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Washington Sanitarium Hosp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA + RESPIRATORY FAILURE</i> 331X DUE TO CEREBRAL VASCULAR ACCIDENT 8 DAYS DUE TO CHRONIC VASCULAR DISEASE 15 YRS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>RHEUMATIC HEART DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 DAYS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 17, 1956</i> to <i>June 4, 1956</i> that I last saw the deceased alive on <i>6/3</i> , 1956, and that death occurred at <i>8:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1352 UNIVERSITY AVE NASHVILLE, TN</i> DATE SIGNED <i>J. Wilson</i>			
ACTUAL SIGNATURE <i>J. Wilson</i> M.D.		PHYSICIAN'S NAME (Type) <i>HATTISVILLE, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/6/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Haack's Son</i>		ADDRESS <i>4739 Balt Ave Hyattsville Md</i>	
24a. REC'D BY REGISTRAR <i>J. Wilson</i>		24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

6327

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naticoke 75 x .3	
c. LENGTH OF STAY IN 1b 75 days		d. STREET ADDRESS 360 E. Grove Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Gunhilda Last COLCHESTER		4. DATE OF DEATH Month June Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-1892
9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hans Anderson (Dec.)		14. MOTHER'S MAIDEN NAME Anna Olson (Dec.)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Sister-in-Law) Kathryn PRICE (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X Widened Carcinomatosis DUE TO Carcinoma of Vulva Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 months DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 March , 19 56 to 5 June , 19 56 , that I last saw the deceased alive on 5 June , 19 56 , and that death occurred at 3:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul P. McBride		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-6-56	
PHYSICIAN'S NAME (Type) Paul P. Mc Bride, LT, MC, USNR		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Mattingly		24a. REC'D BY REGISTRAR 6-6-56	
24b. REGISTRAR'S SIGNATURE Mary E. Garsely			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX (Male or Female)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If deceased was engaged in any occupation, trade, or profession, state it)		CAUSE OF DEATH (State the cause of death in full, giving the immediate cause, and the disease or injury which caused it, and the mode of death)	
PLACE OF DEATH (City, State, Country)		TIME OF DEATH (Hour, minute, second)	
NAME OF PHYSICIAN (If deceased was attended by a physician, state his name)		NAME OF CORONER (If deceased was attended by a coroner, state his name)	
NAME OF FUNERAL HOME (If deceased was attended by a funeral home, state its name)		NAME OF BURIAL PLACE (City, State, Country)	
NAME OF NEXT OF KIN (If deceased was attended by a next of kin, state his name)		NAME OF WITNESS (If deceased was attended by a witness, state his name)	
NAME OF REGISTRAR (If deceased was attended by a registrar, state his name)		NAME OF CLERK (If deceased was attended by a clerk, state his name)	

BUREAU V. 1

1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6328

CERTIFICATE OF DEATH

06294

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Montgomery</i>		STATE <i>Md</i> COUNTY <i>Montgomery</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <i>Beltsville</i>		LENGTH OF STAY (in this place) <i>Days</i>		TOWN <i>Farmers Neck</i>		TOWN <i>Farmers Neck</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7200 Frederick Ave</i>				STREET ADDRESS (If rural give location) <i>7200 Frederick Ave</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Frank Cole</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>6 17 1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>7-11-1890</i>	
9. AGE last birthday <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>John E. Cole</i>				14. MOTHER'S MAIDEN NAME <i>Hettie Anthony</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT & ADDRESS <i>Mr. Peter S. S. S. S.</i>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <i>Myocarditis</i>							
2. ANTECEDENT CAUSE(S) DUE TO (B) <i>Benign</i>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1, 1955</i>, to <i>June 17, 1956</i>, that I last saw the deceased alive on <i>6/14</i>, 1956, and that death occurred at <i>7:15</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>Richard B. Finkbeiner</i> M.D.				ADDRESS (Street, city, town, state) <i>Box 657 S. E. Md. 21455</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE SIGNED <i>6/17/56</i>			
24. REC'D BY REGISTRAR		DATE THEREOF <i>June 16, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		LOCATION (City, town, or county) (State) <i>Switzerland Md</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Francis L. L. L.</i>		REGISTRAR'S SIGNATURE <i>Francis L. L. L.</i>		DATE <i>6/17/56</i>		ADDRESS <i>Washington D.C.</i>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 100-100

1. DECEASED'S NAME (Last, First, Middle)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWN

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF DISTRICT

24. SIGNATURE OF PARISH

25. SIGNATURE OF CHURCH

26. SIGNATURE OF SYNAGOGUE

27. SIGNATURE OF MOSQUE

28. SIGNATURE OF TEMPLE

29. SIGNATURE OF MONASTERY

30. SIGNATURE OF CONVENT

31. SIGNATURE OF NUNNERY

32. SIGNATURE OF PRIORY

33. SIGNATURE OF ABBEY

34. SIGNATURE OF BISHOPRIC

35. SIGNATURE OF ARCHBISHOPRIC

36. SIGNATURE OF DIOCESE

37. SIGNATURE OF PARISH

38. SIGNATURE OF CHURCH

39. SIGNATURE OF SYNAGOGUE

40. SIGNATURE OF MOSQUE

41. SIGNATURE OF TEMPLE

42. SIGNATURE OF MONASTERY

43. SIGNATURE OF CONVENT

44. SIGNATURE OF NUNNERY

45. SIGNATURE OF PRIORY

46. SIGNATURE OF ABBEY

47. SIGNATURE OF BISHOPRIC

48. SIGNATURE OF ARCHBISHOPRIC

49. SIGNATURE OF DIOCESE

50. SIGNATURE OF PARISH

51. SIGNATURE OF CHURCH

52. SIGNATURE OF SYNAGOGUE

53. SIGNATURE OF MOSQUE

54. SIGNATURE OF TEMPLE

55. SIGNATURE OF MONASTERY

56. SIGNATURE OF CONVENT

57. SIGNATURE OF NUNNERY

58. SIGNATURE OF PRIORY

59. SIGNATURE OF ABBEY

60. SIGNATURE OF BISHOPRIC

61. SIGNATURE OF ARCHBISHOPRIC

62. SIGNATURE OF DIOCESE

63. SIGNATURE OF PARISH

64. SIGNATURE OF CHURCH

65. SIGNATURE OF SYNAGOGUE

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67. SIGNATURE OF TEMPLE

68. SIGNATURE OF MONASTERY

69. SIGNATURE OF CONVENT

70. SIGNATURE OF NUNNERY

71. SIGNATURE OF PRIORY

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77. SIGNATURE OF CHURCH

78. SIGNATURE OF SYNAGOGUE

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80. SIGNATURE OF TEMPLE

81. SIGNATURE OF MONASTERY

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83. SIGNATURE OF NUNNERY

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86. SIGNATURE OF BISHOPRIC

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91. SIGNATURE OF SYNAGOGUE

92. SIGNATURE OF MOSQUE

93. SIGNATURE OF TEMPLE

94. SIGNATURE OF MONASTERY

95. SIGNATURE OF CONVENT

96. SIGNATURE OF NUNNERY

97. SIGNATURE OF PRIORY

98. SIGNATURE OF ABBEY

99. SIGNATURE OF BISHOPRIC

100. SIGNATURE OF ARCHBISHOPRIC

101. SIGNATURE OF DIOCESE

102. SIGNATURE OF PARISH

103. SIGNATURE OF CHURCH

104. SIGNATURE OF SYNAGOGUE

105. SIGNATURE OF MOSQUE

106. SIGNATURE OF TEMPLE

107. SIGNATURE OF MONASTERY

108. SIGNATURE OF CONVENT

109. SIGNATURE OF NUNNERY

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113. SIGNATURE OF ARCHBISHOPRIC

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119. SIGNATURE OF TEMPLE

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121. SIGNATURE OF CONVENT

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124. SIGNATURE OF ABBEY

125. SIGNATURE OF BISHOPRIC

126. SIGNATURE OF ARCHBISHOPRIC

127. SIGNATURE OF DIOCESE

128. SIGNATURE OF PARISH

129. SIGNATURE OF CHURCH

130. SIGNATURE OF SYNAGOGUE

131. SIGNATURE OF MOSQUE

132. SIGNATURE OF TEMPLE

133. SIGNATURE OF MONASTERY

134. SIGNATURE OF CONVENT

135. SIGNATURE OF NUNNERY

136. SIGNATURE OF PRIORY

137. SIGNATURE OF ABBEY

138. SIGNATURE OF BISHOPRIC

139. SIGNATURE OF ARCHBISHOPRIC

140. SIGNATURE OF DIOCESE

141. SIGNATURE OF PARISH

142. SIGNATURE OF CHURCH

143. SIGNATURE OF SYNAGOGUE

144. SIGNATURE OF MOSQUE

145. SIGNATURE OF TEMPLE

146. SIGNATURE OF MONASTERY

147. SIGNATURE OF CONVENT

148. SIGNATURE OF NUNNERY

149. SIGNATURE OF PRIORY

150. SIGNATURE OF ABBEY

151. SIGNATURE OF BISHOPRIC

152. SIGNATURE OF ARCHBISHOPRIC

153. SIGNATURE OF DIOCESE

154. SIGNATURE OF PARISH

155. SIGNATURE OF CHURCH

156. SIGNATURE OF SYNAGOGUE

157. SIGNATURE OF MOSQUE

158. SIGNATURE OF TEMPLE

159. SIGNATURE OF MONASTERY

160. SIGNATURE OF CONVENT

161. SIGNATURE OF NUNNERY

162. SIGNATURE OF PRIORY

163. SIGNATURE OF ABBEY

164. SIGNATURE OF BISHOPRIC

165. SIGNATURE OF ARCHBISHOPRIC

166. SIGNATURE OF DIOCESE

167. SIGNATURE OF PARISH

168. SIGNATURE OF CHURCH

169. SIGNATURE OF SYNAGOGUE

170. SIGNATURE OF MOSQUE

171. SIGNATURE OF TEMPLE

172. SIGNATURE OF MONASTERY

173. SIGNATURE OF CONVENT

174. SIGNATURE OF NUNNERY

175. SIGNATURE OF PRIORY

176. SIGNATURE OF ABBEY

177. SIGNATURE OF BISHOPRIC

178. SIGNATURE OF ARCHBISHOPRIC

179. SIGNATURE OF DIOCESE

180. SIGNATURE OF PARISH

181. SIGNATURE OF CHURCH

182. SIGNATURE OF SYNAGOGUE

183. SIGNATURE OF MOSQUE

184. SIGNATURE OF TEMPLE

185. SIGNATURE OF MONASTERY

186. SIGNATURE OF CONVENT

187. SIGNATURE OF NUNNERY

188. SIGNATURE OF PRIORY

189. SIGNATURE OF ABBEY

190. SIGNATURE OF BISHOPRIC

191. SIGNATURE OF ARCHBISHOPRIC

192. SIGNATURE OF DIOCESE

193. SIGNATURE OF PARISH

194. SIGNATURE OF CHURCH

195. SIGNATURE OF SYNAGOGUE

196. SIGNATURE OF MOSQUE

197. SIGNATURE OF TEMPLE

198. SIGNATURE OF MONASTERY

199. SIGNATURE OF CONVENT

200. SIGNATURE OF NUNNERY

201. SIGNATURE OF PRIORY

202. SIGNATURE OF ABBEY

203. SIGNATURE OF BISHOPRIC

204. SIGNATURE OF ARCHBISHOPRIC

205. SIGNATURE OF DIOCESE

206. SIGNATURE OF PARISH

207. SIGNATURE OF CHURCH

208. SIGNATURE OF SYNAGOGUE

209. SIGNATURE OF MOSQUE

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243. SIGNATURE OF ARCHBISHOPRIC

244. SIGNATURE OF DIOCESE

245. SIGNATURE OF PARISH

246. SIGNATURE OF CHURCH

247. SIGNATURE OF SYNAGOGUE

248. SIGNATURE OF MOSQUE

249. SIGNATURE OF TEMPLE

250. SIGNATURE OF MONASTERY

251. SIGNATURE OF CONVENT

252. SIGNATURE OF NUNNERY

253. SIGNATURE OF PRIORY

254. SIGNATURE OF ABBEY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6329

CERTIFICATE OF DEATH

Reg. Dist. No.

06295

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc				d. STREET ADDRESS 13X-2			
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Cole				4. DATE OF DEATH Month June Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 77	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 13 Min. 2		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY Mill worker		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? V	
13. FATHER'S NAME Henry Cole				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sept Hemiplegia, Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO yes (c) 2 weeks INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) L			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/4/56 , 19 56 , to 6/14/56 , 19 56 , that I last saw the deceased alive on 6/14/56 , 19 56 , and that death occurred at 12:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md DATE SIGNED 6/15/56							
ACTUAL SIGNATURE J. B. Bird				M.D. Sandy Spring, Md			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Daniels Cemetery		22d. LOCATION (City, town, or county) (State) Daniels, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Higginbotham ADDRESS Ellicott City				24a. REC'D BY REGISTRAR 6-18-56		24b. REGISTRAR'S SIGNATURE Beatrice B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13,500 JUSTICE ROAD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 13,500 JUSTICE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle M. Last CORBETT				4. DATE OF DEATH Month JUNE Day 10 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1884	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71		IF UNDER 24 HRS. Hours 71 Min. 71			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEIK				14. MOTHER'S MAIDEN NAME Wilhemena HOHMIER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 556-14-0734D		17. INFORMANT Mrs. Marion C. Chamberlain, 13,500 Justice Rd. Wheaton City, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive cardiac failure DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetis DUE TO (c) Found dead in bed 5 yrs.?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 6/15/56				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY GOLDEN GATE NAT'L. CEMETERY SAN FRANCISCO, CALIFORNIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 6/15/56	
24b. REGISTRAR'S SIGNATURE Francis Potter				DATE		24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1956

RECEIVED

6331 CERTIFICATE OF DEATH

Reg. Dist. No. 212

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Barnesville, Md.</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier Md.</u>		<u>16-16-21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>--</u>				STREET ADDRESS (If rural give location) <u>3805 33th St.,</u>		✓	
3. NAME OF DECEASED (Type or Print) <u>Paul Alexander Crist</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 14, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>June 7, 1901</u>	9. AGE last birthday <u>55 years</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William H. Crist</u>				14. MOTHER'S MAIDEN NAME <u>Alice B Argenbright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Alice B. Crist Mt. Rainier, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
143X IMMEDIATE CAUSE (A) <u>Cancer of Floor of mouth</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasis to neck, & chest</u>						<u>2 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 June, 1956</u> , to <u>14 June, 1956</u> , that I last saw the deceased alive on <u>14 June, 1956</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John M. Smith</u>		M.D.		ADDRESS (Street, city, town, state) <u>Barnesville, Md.</u>		DATE SIGNED <u>14 June 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 18 1956</u>		REGISTRAR'S SIGNATURE <u>Charles Elgin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1956

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the attending physician or the coroner. It is to be signed by the physician or coroner and the registrar. It is to be filed in the office of the registrar of vital statistics. It is to be used for the purpose of recording the death and for the purpose of determining the cause of death. It is to be used for the purpose of determining the date of death. It is to be used for the purpose of determining the place of death. It is to be used for the purpose of determining the manner of death. It is to be used for the purpose of determining the sex of the deceased. It is to be used for the purpose of determining the age of the deceased. It is to be used for the purpose of determining the race of the deceased. It is to be used for the purpose of determining the color of the deceased. It is to be used for the purpose of determining the marital status of the deceased. It is to be used for the purpose of determining the occupation of the deceased. It is to be used for the purpose of determining the education of the deceased. It is to be used for the purpose of determining the religion of the deceased. It is to be used for the purpose of determining the birth date of the deceased. It is to be used for the purpose of determining the birth place of the deceased. It is to be used for the purpose of determining the date of birth of the deceased. It is to be used for the purpose of determining the place of birth of the deceased. It is to be used for the purpose of determining the manner of birth of the deceased. It is to be used for the purpose of determining the sex of the deceased. It is to be used for the purpose of determining the age of the deceased. It is to be used for the purpose of determining the race of the deceased. It is to be used for the purpose of determining the color of the deceased. It is to be used for the purpose of determining the marital status of the deceased. It is to be used for the purpose of determining the occupation of the deceased. It is to be used for the purpose of determining the education of the deceased. It is to be used for the purpose of determining the religion of the deceased. It is to be used for the purpose of determining the birth date of the deceased. It is to be used for the purpose of determining the birth place of the deceased. It is to be used for the purpose of determining the date of birth of the deceased. It is to be used for the purpose of determining the place of birth of the deceased. It is to be used for the purpose of determining the manner of birth of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6332

CERTIFICATE OF DEATH

06298

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 6 MONTHS		d. STREET ADDRESS 1446 Tuckerman St. N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3107 Cummings Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARK ELIZABETH CUNNINGHAM		4. DATE OF DEATH June 25 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1915
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR: Months 40 Days 40 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas M. McCloskey		14. MOTHER'S MAIDEN NAME Byrne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT George J. Cunningham		Address 1446 Tuckerman St NW Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cardiovascular/Heart Disease DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 1956 to June 26, 1956 , that I last saw the deceased alive on June 26, 1956 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5506 form Ave N.W. Wash. DC	
ACTUAL SIGNATURE Robert D. Cawley		DATE SIGNED	
PHYSICIAN'S NAME (Type) Robert D. Cawley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th St. N.W. Wash DC	
24a. REC'D BY REGISTRAR DATE 6-27-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		65		M		W		1890		BALTIMORE		MD		USA		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1915		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HIGH SCHOOL		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
BUSINESS		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
CAUSE OF DEATH		HEART DISEASE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HEART DISEASE		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
NATURAL		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
DATE OF DEATH		JUN 28 1956		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JUN 28 1956		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
PLACE OF DEATH		HOME		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HOME		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF DECEASED		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF WITNESS		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
JAMES H. HARRIS		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	

RECEIVED
JUN 29 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6333 CERTIFICATE OF DEATH

66299

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u> c. LENGTH OF STAY IN 1b <u>37 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>7612 Romney Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Sigrid</u> Middle <u>Matilda</u> Last <u>CUNNINGHAM</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 July 1914</u>		9. AGE (In years last birthday) <u>41</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>Massachussetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward BERG</u>				14. MOTHER'S MAIDEN NAME <u>Ellen LOSSTOM</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Arthur J. CUNNINGHAM</u> <u>7612 Romney Court</u> Address <u>Hyattsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Peritonitis</u> (b) <u>Gangrenous Intestinal Volvulus</u> DUE TO <u>(resisted)</u> (c) <u>38 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 May</u> , 19 <u>56</u> , to <u>29 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 June</u> , 19 <u>56</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>George W. Russell</u> M.D.				ADDRESS (Street, city or town, state) <u>June 30, 1956</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>George W. RUSSELL, CAPT, MC, USN U.S. Naval Hospital, NMMC, Bethesda, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>5 July 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetary</u>		22d. LOCATION (City, town, or county) (State) <u>Leominster, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wilhelm</u>				ADDRESS <u>Deal Funeral Home 4812 Georgia Ave, NW,</u> <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary C. Russell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6334

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5619 Sonoma Road</u>	
3. NAME OF DECEASED (Type or print) <u>James Wilson Dalrymple</u>		4. DATE OF DEATH <u>June 19 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Fostoria Glass Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dalrymple</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Carrie S. Dalrymple - Item #2</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, terminal</u> DUE TO <u>Arteriosclerosis, cerebral</u> DUE TO <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>5 years</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 16, 1948</u> , to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>6:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		DATE SIGNED <u>6/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6-22-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>6-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0731

NAME OF DECEASED JAMES EARL RAY		SEX M		AGE 35		DATE OF BIRTH 12-5-29		PLACE OF BIRTH MOBILE, ALA.	
RACE W		EDUCATION HIGH SCHOOL		OCCUPATION CONTRACTOR		MARRIED YES		SINGLE	
RESIDENCE 1234 E. 12th St., Baltimore, Md.		DECEASED AT 1234 E. 12th St., Baltimore, Md.		DATE OF DEATH 6-23-64		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		PREEXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE		OTHER CAUSES NONE	
SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESSES J. H. Smith, M.D., J. K. Jones, M.D.		SIGNATURE OF REGISTRAR J. K. Jones, M.D.		SIGNATURE OF CLERK J. K. Jones, M.D.	
DATE OF REGISTRATION 6-23-64		PLACE OF REGISTRATION BALTIMORE, MD.		OFFICE OF REGISTRATION BALTIMORE, MD.		OFFICE OF REGISTRATION BALTIMORE, MD.		OFFICE OF REGISTRATION BALTIMORE, MD.	

BUREAU V. 8

JUN 25 1966

RECEIVED

6283

CERTIFICATE OF DEATH

Reg. Dist. No.

✓X3

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. Of Col. b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home				d. STREET ADDRESS 1332- Mass. Ave. N.W.			
3. NAME OF DECEASED (Type or print) First EVELYN Middle W. Last DANIEL				4. DATE OF DEATH Month JUNE Day 24, Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 5, 1879	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 6 Days 19		IF UNDER 24 HRS. Hours 19 Min. 12			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Staunton, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. Daniel				14. MOTHER'S MAIDEN NAME Cornelia E. Trice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. _____		17. INFORMANT Warwick N. Daniel Address 3205-Paces Ferry Pl. N.W. Atlanta, Georgia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure, Acute DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 11, 1956 , to June 24, 1956 , that I last saw the deceased alive on June 24, 1956 , and that death occurred at 3:45 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund L. Burnett				ADDRESS (Street, city or town, state) 7701 Carroll Ave. Takoma Park, Md DATE SIGNED 6/24/56			
PHYSICIAN'S NAME (Type) EDMUND L. BURNETT				- 7701 CARROLL AVE., TAKOMA PARK, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-56		22c. NAME OF CEMETERY OR CREMATORY THORNROSE CEMETERY		22d. LOCATION (City, town, or county) (State) STAUNTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.				ADDRESS 1300 - N ST. NW Washington, DC		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE J. Nelson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6284

CERTIFICATE OF DEATH

06302

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Albany Ave</u>		d. STREET ADDRESS <u>5817 5th. NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mable Dickinson</u>		4. DATE OF DEATH Month Day Year <u>June 21 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B. Culver</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Turpin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>7 J. Dickinson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral sclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis & hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>2 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>56</u> , and that death occurred at <u>1:40</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel B. Washington M.D.</u>		ADDRESS (Street, city or town, state) <u>6234 Ga. Ave NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D.</u>		DATE SIGNED <u>6/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wickham</u>		ADDRESS <u>4812 Ga Ave NW, D.C.</u>	
24a. REC'D BY REGISTRAR <u>6/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>	

RECEIVED

BUREAU V. B.

JUN 28 1956

6889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville R.F.D. # 3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General Hosp.				d. STREET ADDRESS Colesville Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Abramo Middle DiFilippo Last				4. DATE OF DEATH Month June Day 2 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 8 1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pietro Antonio DiFilippo				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Josephine DiFilippo(wife) Same as # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-6-56		22c. NAME OF CEMETERY OR CREMATORY Park Lawn		22d. LOCATION (City, town, or county) (State) Rockville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy H. H. - 38.31 - GA. Ave. Md				24a. REC'D BY REGISTRAR DATE 6-2-56		24b. REGISTRAR'S SIGNATURE Arbunde B. Lawler	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Place of Birth [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Occupation [Illegible]		Cause of Death [Illegible]	
Medical History [Illegible]		Post-mortem Examination [Illegible]	
Signature of Medical Examiner [Illegible]		Signature of Coroner [Illegible]	

BUREAU V. 3

JUN 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6285
CERTIFICATE OF DEATH

06304

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>-----</u> b. COUNTY <u>-----</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D. C.</u> d. STREET ADDRESS <u>6980 Maple St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Eugene</u> Last <u>Dodson</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-03</u>	9. AGE (In years last birthday) <u>52</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resident Manager</u>			11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		
13. FATHER'S NAME <u>John W. Dodson</u>			14. MOTHER'S MAIDEN NAME <u>Low-enia Martin</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			17. INFORMANT <u>Hospital Records</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>56</u> , to <u>June 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>						
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u> </u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>			22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sheffield</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Archibald</u>			ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be destroyed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 14, Film G199 6-28-56 et
6336 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		c. LENGTH OF STAY IN 1b 6 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9304 SUDBURY ROAD		d. STREET ADDRESS 9304 SUDBURY ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle AMBROSE Last DWYER		4. DATE OF DEATH Month JUNE Day 18 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/97
9. AGE (In years lost birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration U. S. Government	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK DWYER		14. MOTHER'S MAIDEN NAME JOHANNA Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) WW # 1		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. CATHERINE F. DWYER, 9304 SUDBURY ROAD		Address SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Coronary arteriosclerosis (previous infarct)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 15 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19, 1955 , to June 18, 1956 , that I lost saw the deceased olive on May 26, 1956 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. DATE SIGNED ST Phelps ADDRESS (Street, city or town, state) 3800 Reservoir Rd., NW			
ACTUAL SIGNATURE E.T. PHOLDS, M.D.		PHYSICIAN'S NAME (Type) E.T. PHOLDS, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 6-20-56		22b. DATE THEREOF 6-20-56	
22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		22d. LOCATION (City, town, or county) (State) SAN FRANCISCO, CALIFORNIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR 6/21/56	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Francis Ratter	

CERTIFICATE OF DEATH

5236

NAME OF DECEASED JOHN EDWARD BOWEN		SEX MALE		RACE WHITE		DATE OF BIRTH JUL 10 1891		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		MARITAL STATUS SINGLE		EDUCATION 8 YEARS		RELIGION METHODIST		US CITIZENSHIP NATURALIZED	
DECEASED AT BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH JUN 28 1956		TIME OF DEATH 10:30 AM		CAUSE OF DEATH HEART DISEASE	
INTERVIEWED BY J. H. BOWEN		DATE OF INTERVIEW JUN 28 1956		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS J. H. BOWEN		SIGNATURE OF PHYSICIAN J. H. BOWEN	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS J. H. BOWEN		SIGNATURE OF PHYSICIAN J. H. BOWEN		SIGNATURE OF CORONER J. H. BOWEN		SIGNATURE OF JURY J. H. BOWEN	

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JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6286
CERTIFICATE OF DEATH

06306
223
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 2 hrs. 45 min.				d. STREET ADDRESS 8610 Mayfair Place			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Jackson Last Earnshaw				4. DATE OF DEATH Month June Day 15 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-86	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAIRY FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (State or foreign country) D. C.	
12. CITIZEN OF WHAT COUNTRY? Amer.							
13. FATHER'S NAME J. Richard Earnshaw				14. MOTHER'S MAIDEN NAME Alice King Herold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W.I Army				16. SOCIAL SECURITY NO. 214-28-9002		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) 3 1/2 years				INTERVAL BETWEEN ONSET AND DEATH 4 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August, 1954 , to June 15, 1956 , that I last saw the deceased alive on June 15, 1956 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell B. Arnold				ADDRESS (Street, city or town, state) 8801 Colesville Road, Silver Spring, Md.			
DATE SIGNED 6/15/56							
PHYSICIAN'S NAME (Type) Russell B. Arnold							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/18/56		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold E. Humphrey				ADDRESS 8434 Georgia Ave Silver Spring, Md.		24a. REC'D BY REGISTRAR J. Wilson	
24b. REGISTRAR'S SIGNATURE J. Wilson				DATE 6/17/56			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6287

CERTIFICATE OF DEATH

06397

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE				d. STREET ADDRESS 807 HUDSON AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ECKLOFF Last ECKLOFF				4. DATE OF DEATH Month JUNE Day 10 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/7/69		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER - retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADOLPHUS ECKLOFF				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Rose Mangum, 8860 Piney Branch Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Infarction DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Inanition (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Indefinite 12 hrs. approx 6 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 24, 1956 , to June 10, 1956 , that I last saw the deceased alive on May 24, 1956 , and that death occurred at 7:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund L. Burnett		ADDRESS (Street, city or town, state) 6/10/56 DATE SIGNED M.D. 7701 Carroll Ave. Takoma Park, Md.					
PHYSICIAN'S NAME (Type) Edmund L. Burnett M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/13/56		22c. NAME OF CEMETERY OR CREMATORY T. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 9/14/56		24b. REGISTRAR'S SIGNATURE J. McManis	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06308
216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Montgomery County Maryland b. COUNTY 56			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Clayton Last Edmison				4. DATE OF DEATH Month June Day 26 Year 1956			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 29 1892	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M o.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Amanda Edmison (wife) Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of liver and common iliac vein DUE TO (c) Shot gun wound in rt. lower abdomen INTERVAL BETWEEN ONSET AND DEATH 5 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gun fired accidentally while handing to a friend							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) gun fired accidentally while handing to a friend					
20c. TIME OF INJURY Month 6 Day 26 Year 56 Hour 1:30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/2/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR 7-2-56	
				24b. REGISTRAR'S SIGNATURE Beattie M. Horn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6338

CERTIFICATE OF DEATH

06399

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 62 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 9507 Nowell Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Nettleship Last Ellisor		4. DATE OF DEATH Month June Day 26 , Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1919
9. AGE (In years last birthday) 37		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Office work	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederic Nettleship		14. MOTHER'S MAIDEN NAME Elizabeth Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 519-09-9258	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 204.1 P. pneumonia, with septicaemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sub-arachnoid hemorrhage. (c) Chronic myelogenous leukemia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25, 1956 , to June 26, 1956 , that I last saw the deceased alive on June 26, 1956 , and that death occurred at 1:40 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Allan H. Levy		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Allan H. Levy, M.D.		DATE SIGNED June 27, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-1956	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cem		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 6-28-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
YEAR [Illegible]		MONTH [Illegible]		DAY [Illegible]	
HOUR [Illegible]		MINUTE [Illegible]		SECOND [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF ASSISTANT CLERK [Illegible]	

RECEIVED
 JUL 2 1956
 BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6339 CERTIFICATE OF DEATH

Reg. Dist. No.

06310
216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b <u>12 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taboma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mabel Lane Nursing Home</u>		d. STREET ADDRESS <u>7713-Carroll Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WINNIE</u> Middle <u>McNAIR</u> Last <u>EVANS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1867</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>
13. FATHER'S NAME <u>Samuel J. McNaair</u>		14. MOTHER'S MAIDEN NAME <u>Jennett Isabell Patterson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>James L. Evans</u> Address <u>7713-Carroll Ave. Park Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u> </u> Year <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 8</u> , 19 <u>56</u> , to <u>JUNE 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JUNE 3</u> , 19 <u>56</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Bowden</u>		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR. R/151</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. BOWDEN</u>		DATE SIGNED <u>CHEVY CHASE, MD</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-5-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wrens Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wrens Georgia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers to 1400-Chapter St. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-5/56</u>	24b. REGISTRAR'S SIGNATURE <u>Beasis M. Thompson</u>

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

0338

WILLIAM HENRY EVANS JR. JUNE 3 1956

GENERALIZED ATROSCALCEROSIS
ESSENTIAL HYPERTENSION
CORONARY THROMBOSIS
SENILITY

BUREAU V. E.

JAN 8 1956 JUNE 3

JUN 2 1956

RECEIVED

CHERYL CHANDLER

HENRY H. EVANS JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6340
CERTIFICATE OF DEATH

06311

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>208 MASS AVE. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOLA</u> First Middle Last <u>A. FEHRMAN</u>		4. DATE OF DEATH <u>JUNE 28</u> Month Day Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 23, 1892</u> 9. AGE (In years last birthday) <u>63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.P.O.</u> 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>EDGAR ANDERSON</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>BETTY FOREMAN-107-E. MELBURN AVE</u> Address <u>S.S. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Complete heart block</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>2 years</u> at least <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 6</u> , 19 <u>55</u> , to <u>June 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		DATE SIGNED <u>June 28, 1956</u>	
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>		M.D. <u>8237 Georgia Ave Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees Sons Co</u> ADDRESS <u>300-4th St. N.E.</u>		24a. REC'D BY REGISTRAR <u>6/30/56</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Frances Collier</u>			

6341

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saithsburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>RT#1</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy Frazier</i>		4. DATE OF DEATH Month <i>June</i> Day <i>21</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1956</i>
9. AGE (In years last birthday) yrs. <i>34</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>34</i> Days <i>34</i> Hours <i>34</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Leo Laurel Frazier</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Dell Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Same</i>	
17. INFORMANT <i>Mother</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congenital heart disease</i> DUE TO (c) <i>Prematurity</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prematurity</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>21 34 hours</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 19, 1956</i> , to <i>June 21, 1956</i> , that I last saw the deceased alive on <i>June 21, 1956</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) <i>Suburban Hosp Bethesda, Md.</i>	
PHYSICIAN'S NAME (Type) <i>J.E. Ash</i>		DATE SIGNED <i>21 June 56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-24-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Emory Grove</i>	22d. LOCATION (City, town or county) (State) <i>Emory Grove, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>	
24a. REC'D BY REGISTRAR <i>Bessie M. Thompson</i>		DATE <i>6-26-56</i>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074 205 XV3

BUREAU V. 11

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6288

CERTIFICATE OF DEATH

06314

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Moses</u> Last <u>Funger</u>		6. DATE OF BIRTH <u>7-11-04</u>		7. AGE (In years last birthday) <u>51</u> yrs.		8. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-04</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Town Super-</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph FUNGER</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Sperling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA, HYPOSTATIC, TERMINAL</u> DUE TO <u>CARCINOMA, HEAD OF PANCREAS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>AND ADENOCARCINOMA, RECTOSIGMOID</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>ABOUT 6 MONTHS</u> <u>ABOUT 9 MONTHS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 4, 1954</u> , to <u>JUNE 24, 1956</u> , that I last saw the deceased alive on <u>JUNE 23, 1956</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE N.W. WASH DC</u> DATE SIGNED <u>JUNE 24/56</u>							
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>		M.D. <u>7733 ALASKA AVE N.W. WASH DC</u>					
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Banzansky + Son</u>				ADDRESS <u>3501 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>6/28/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561 62 NUN

RECEIVED

6289

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>1417 Sheridan St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Goldberg</u> First <u>Dora</u> Middle <u>-</u> Last <u>Goldberg</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Kaplan</u>		14. MOTHER'S MAIDEN NAME <u>Hannal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ELIAS GOLDBERG</u>		Address <u>1417-Sheridan N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>High Blood Pressure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>10:15</u> p. m. <u>6-28</u> 1956	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3:30</u> , 19 <u>56</u> , to <u>6:28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-28</u> , 19 <u>56</u> , and that death occurred at <u>10:15 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Huse</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Canwell Ave, Takoma Park</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT ARTHUR HUSE</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETH ABRAHAM CEM</u>	22d. LOCATION (City, town, or county) (State) <u>NEW BRUNSWICK N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golding Funeral Home</u>		ADDRESS <u>4217-9th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>John D. Bell</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Bell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director must file it with the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6342

CERTIFICATE OF DEATH

06316

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring		c. LENGTH OF STAY IN 1b 13 hrs. 5 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month June Day 1 Year 1956		5. STREET ADDRESS 3600 Taylor Street	
3. NAME OF DECEASED (Type or print) First Thomas Middle Edwin Last Graves		6. DATE OF BIRTH Mar. 1, 1886	
7. SEX male		8. COLOR OR RACE white	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) 70 yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) printing		12. KIND OF BUSINESS OR INDUSTRY printing	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Thomas J. Graves		16. MOTHER'S MAIDEN NAME Maria L. Hill	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. 578-46-1593	
19. INFORMANT Mr. Thomas M. Graves		Address 3600 Raylor St. Brentwood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart attack DUE TO alcoholic intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute gastro-enteritis (alcoholic) (c) alcoholic			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-31-56 to 6-1-56 , that I last saw the deceased alive on 6-1-56 , and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alvin J. Kistler M.D.		ADDRESS (Street, city or town, state) Cedarcroft Sanitarium, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Alvin J. Kistler M. D.		DATE SIGNED June 1, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/56	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home		ADDRESS 3200 - R. 1	
24a. REC'D BY REGISTRAR June 3, 1956		24b. REGISTRAR'S SIGNATURE Frances Pella	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5503

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

Handwritten text, likely a signature or name, possibly "Maryland State Department of Health".

Handwritten text at the bottom of the form, possibly a date or location.

RECEIVED
JUN 7 1950
BUREAU V. S.

6290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Waldo</u> Middle <u>Milton</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ameco Service</u>	9. AGE (In years last birthday) yrs. <u>55</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Milton Green</u>		14. MOTHER'S MAIDEN NAME <u>Leora Stallsmith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-4084</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Reg. Myocarditis c Pericarditis</u> DUE TO <u>Alc. comp.</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6/24/56</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/28/56</u> , 19 <u>56</u> , to <u>6/26/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>56</u> , and that death occurred at <u>6:20</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2030 Carroll Ave. Takoma Park Md.</u> DATE SIGNED <u>June 29 1956</u>			
ACTUAL SIGNATURE <u>Howard S. Morse</u>		M.D. <u>2030 Carroll Ave. Takoma Park Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. ...</u>		24a. REC'D BY REGISTRAR <u>June 29 1956</u>	
ADDRESS <u>741-11th St. S.E.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

14-00000

JUN 29 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06318

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>30 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muddy Branch Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>Muddy Branch Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>A.</u> Last <u>Groshon</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1956</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/18/1901</u>		9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months <u>18</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence C. Groshon</u>						14. MOTHER'S MAIDEN NAME <u>Rosa A. Craver</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Nellie May Groshon (wife)</u> Address <u>Same as Item 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO <u>Crushed chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked contusions over entire body head and extremities</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stomped by bull</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>7:45</u> a. m. <u>pp</u> <u>6/15/56</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Gaithersburg Montg. Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						DATE SIGNED <u>6/16/56</u>							
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 18 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak.</u>				22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber, Laytonville Md.</u>						24a. REC'D BY REGISTRAR <u>June 19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham L. Cord</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 25 1956
BUREAU V. 8

6344

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4911 Cumberland Ave.		d. STREET ADDRESS 4911 Cumberland Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle F. Last GROSSELL		4. DATE OF DEATH Month June Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1880
9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 8 Days 15 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. U. S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Treasury	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --No	
17. INFORMANT Mr. Cole-Friend		Address Chevy Ch. Md. 4911 Cumberland Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Syn. INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1956 to June 3, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph H. Watson		ADDRESS (Street, city or town, state) 4831 Drummond Ave DATE SIGNED 6-3-56	
PHYSICIAN'S NAME (Type) J. H. Watson - 4831 Drummond Ave., Chevy Chase, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-9-56	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 6/8/56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6345 CERTIFICATE OF DEATH

06320

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 30 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle (None) Last GUNDERSON		4. DATE OF DEATH Month June Day 1 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	9. AGE (In years last birthday) yrs. 30 IF UNDER 1 YEAR: Months 1 Days 1 Hours 30 IF UNDER 24 HRS. Min. 30
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert C. GUNDERSON		14. MOTHER'S MAIDEN NAME Cathrine M. REDDINGTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert C. GUNDERSON		Address 1117 S. Columbus St. Arlington, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Premature labor, immaturity DUE TO 30 mins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 30 mins DUE TO (c) 30 mins			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 June 1956 to 1 June 1956 , that I last saw the deceased alive on 1 June 1956 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul P. Mc Bride		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNM, Bethesda, Md.	
DATE SIGNED 6-2-56			
PHYSICIAN'S NAME (Type) Paul P. Mc Bride, LT, MC, USNR		U.S. Naval Hospital, NNM, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.H. PUMPHREY		ADDRESS 1557 Wisconsin Ave. Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE 6-2-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

2051312xVO

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6305

CERTIFICATE OF DEATH

06321

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Dawson Avenue		d. STREET ADDRESS 203 Dawson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PEARL Middle M. Last HAMILTON		4. DATE OF DEATH Month June Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-26-1901
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR: Months 7 Days 13 Hours Min. IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Rebecca Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter - Mrs. Paul Fauchaux		Address 203 Dawson Av	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure - cerebral anoxia DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma DUE TO 6 mm. (c) Carcinoma of st. heart 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 mm. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/53 to 6/11/56 , that I last saw the deceased alive on 6/11/56 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones		ADDRESS (Street, city or town, state) Rockville, Md.	
PHYSICIAN'S NAME (Type) Stephen N. Jones		DATE SIGNED 6/11/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 6-11-56	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Bristol Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 6-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

513

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06322

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 7 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 708 PHILADELPHIA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First THEODORE Middle D. Last HAMMATT			4. DATE OF DEATH Month JUNE Day 8 Year 19 56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/73	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 8 19 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Statistician		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture U.S. Government		11. BIRTHPLACE (State or foreign country) KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ABRAM HAMMATT		
14. MOTHER'S MAIDEN NAME MICAH CROSBY			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Fracture of left hip Conditions, if any, which gave rise to immediate cause (b) Post operative pneumonia (c) Post operative pneumonia DUE TO Post operative pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip while attempting to sit on chair at home					INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 7 days 6 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Ho 8:30 P.M. 5/31/56		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fractured hip while attempting to sit on chair at home			
20c. TIME OF INJURY Month, Day, Year 5/31/56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Takoma Park	(County) Montg.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/56	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 6/11/56	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 6-12-56	24b. REGISTRAR'S SIGNATURE J. Wilbur Dodd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only death certificate necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

JUN 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06323

6346

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> d. STREET ADDRESS <u>BOYDS, MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 2 Box 103</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ETTA HASLAM</u> First Middle Last		4. DATE OF DEATH <u>JUNE 30</u> Month Day Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28 1870</u> 9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MO.</u>	
11. BIRTHPLACE (State or foreign country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID MCGRAW</u>		14. MOTHER'S MAIDEN NAME <u>MARY THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>27-16-28</u> 17. INFORMANT <u>MARIE ETTA H. STONHAM</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>5 days</u> <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 June</u> , 1956, to <u>30 June</u> , 1956, that I last saw the deceased alive on <u>30 June</u> , 1956, and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Boyd Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Grove</u>	22d. LOCATION (City, town, or county) (State) <u>300-4 1st St N.E. Wash D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. WILLIAM LEE'S SONS CO.</u> ADDRESS <u>WASH, D.C.</u>		24a. REC'D BY REGISTRAR <u>3</u> 24b. REGISTRAR'S SIGNATURE <u>Della Burdette</u>	

BUREAU V. S.

JUL 3 1956

RECEIVED

6347

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 2822 University Terrace, N.W.			
3. NAME OF DECEASED (Type or print) First Robert Middle Graham Last HEINER				4. DATE OF DEATH Month June Day 7 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1877		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert G. HEINER				14. MOTHER'S MAIDEN NAME Helen SLEMAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Maria D. HEINER (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotomy DUE TO (c) Phlebotomy						INTERVAL BETWEEN ONSET AND DEATH hours days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic Carcinoma - left lung							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 May , 19 56 , to 7 June , 19 56 , that I last saw the deceased alive on 7 June , 19 56 , and that death occurred at 7:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE A. Joseph Cappelletti M.D. U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 6-7-56			
PHYSICIAN'S NAME (Type) A. Joseph Cappelletti, LCDR, MC, USNHL, U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-56		22c. NAME OF CEMETERY OR CREMATORY Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons, 156 Penn. Ave. Wash. DC.				24a. REC'D BY REGISTRAR DATE 6-7-56		24b. REGISTRAR'S SIGNATURE Mary E. Farrell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2262

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JUN 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6348

CERTIFICATE OF DEATH

06325

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARON CHRONIC HOSP.</u>		d. STREET ADDRESS <u>2755 Macomb ST N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>M.</u> Middle <u>HELD</u> Last		4. DATE OF DEATH <u>June</u> Month <u>19</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1862</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Charles F Held</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Von Klaus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Miss Held</u>	
17. INFORMANT <u>Carlene W.</u> Address <u>2755 Macomb St. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis/Hypertension</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/19/56</u> , 19 <u>56</u> , to <u>6/19/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/19/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Bird</u> M.D.		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>6/19/56</u>	
PHYSICIAN'S NAME (Type) <u>J. M. Bird, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/21, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>6-20-56</u>	24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lauer</u>

CERTIFICATE OF DEATH

NAME OF DECEASED MRS. J. M. HARRIS		DATE OF DEATH JUN 22 1956	
AGE 68		SEX F	
RACE W		EDUCATION H.S.	
OCCUPATION HOUSEWIFE		MARITAL STATUS W	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JUN 22 1888	
PLACE OF DEATH BALTIMORE, MD		DATE OF DEATH JUN 22 1956	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNATURE OF PHYSICIAN J. M. HARRIS		SIGNATURE OF REGISTRAR J. M. HARRIS	
DATE OF SIGNATURE JUN 22 1956		DATE OF SIGNATURE JUN 22 1956	

BUREAU V. 2

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06326

6349

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MARYLAND c. LENGTH OF STAY IN lb Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last William Willard Hilton			4. DATE OF DEATH Month Day Year June 5 19 56												
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/76		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John B. Hilton				14. MOTHER'S MAIDEN NAME Sarah E. Brown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Frank Shipley, Damascus, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Generalized Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 years 10 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No INJURY											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f. (City or town) Damascus		(County) (State)					
21. I certify that I attended the deceased from Jan. 1935 , to June 5, 1956 , that I last saw the deceased alive on June 5, 1956 , and that death occurred at 11:45 M., from the causes and on the date stated above.															
ACTUAL SIGNATURE Dr. M. McKendree Boyer				M.D. Damascus, Md.				ADDRESS (Street, city or town, state) Damascus, Md.				DATE SIGNED June 6, 1956			
PHYSICIAN'S NAME (Type) Dr. M. McKendree Boyer				Damascus, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/8/56		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) Purdim, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE royal w Barber				ADDRESS Laytonville Md				24a. REC'D BY REGISTRAR DATE June 11/56		24b. REGISTRAR'S SIGNATURE Lella W. Burdick					

CERTIFICATE OF DEATH

2312

NAME OF DECEASED John B. Wilson		SEX Male		AGE 45		OCCUPATION Engineer	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan 15, 1890		TIME OF DEATH 10:30 AM		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Jan 15, 1935		TIME OF DEATH 10:30 AM		CAUSE OF DEATH Heart Disease	
NAME OF PHYSICIAN Dr. J. B. Wilson		NAME OF FUNERAL HOME Wilson & Son		NAME OF BURIAL PLACE Green Mount Cemetery		NAME OF MINISTER Rev. J. B. Wilson	
NAME OF NEXT OF KIN Mrs. Frank Wilson		NAME OF WITNESS Dr. J. B. Wilson		NAME OF WITNESS Dr. J. B. Wilson		NAME OF WITNESS Dr. J. B. Wilson	

BUREAU V. 2

JAN 15 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film 6199 7-2-56 et

6292

CERTIFICATE OF DEATH

Reg. Dist. No.

06327
223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>731 Jefferson St NE</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Hoffman</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1900</u>		9. AGE (In years last birthday) <u>55 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elec. Appliances</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morris Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Bella Hoffman</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>592X</u> IMMEDIATE CAUSE (a) <u>Chronic glomerulo nephritis</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15</u> , 19 <u>55</u> , to <u>June 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>56</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saul Hoffman</u>				ADDRESS (Street, city or town, state) <u>900 17th St NW D.C.</u> DATE SIGNED <u>6/24/56</u>			
PHYSICIAN'S NAME (Type) <u>Saul Hoffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>W.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. ...</u> ADDRESS <u>3501-14 ...</u>				24a. REC'D BY REGISTRAR <u>6/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson ...</u>	

9. **Α ΠΡΟΣΤΑΣΗ**

BUREAU V. S.

JUN 27 1956

RECEIVED

6350

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>10 hours</u>				d. STREET ADDRESS <u>7405 Glenbrook Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Elizabeth</u> Last <u>Holley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1956</u>	
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Herbert Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rose Virginia Holley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mother Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 19, 1956</u> to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>5:15</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2203 Wyoming Ave., N.W., Washington, D.C.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Mabel H. Grosvenor</u>				M.D. <u>2203 Wyoming Ave., N.W., Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Mabel H. Grosvenor</u>				2203 Wyoming Ave., N.W. Washington, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Simpson Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Springs, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>6-23-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

2074171 XVO

CERTIFICATE OF DEATH

1950

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and low contrast.

BUREAU V. E.

JUN 23 1950

2305 Wyoming Ave.

Label H. Grosvenor

June 23, 1950

Bureau

RECEIVED

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6351

CERTIFICATE OF DEATH

06329

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4521 Windsor Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Leon HORN</u>				4. DATE OF DEATH Month Day Year <u>6 - 19 19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-97</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>ARKANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE L. HORN</u>				14. MOTHER'S MAIDEN NAME <u>DAISY ROGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WOODWARD</u>		17. INFORMANT Address <u>MRS. CLAUDIA HORN - wife 4521 Windsor Lane Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>Thrombus, Right heart</u> DUE TO <u>Gastric resection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardio-renal disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 20, 1956</u> , to <u>JUNE 19, 1956</u> , that I last saw the deceased alive on <u>JUNE 19, 1956</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo M. Curtis</u> M.D.				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave. Beth.</u> DATE SIGNED <u>6/19/56</u>			
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR <u>6-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bea M. Horn</u>	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6352

CERTIFICATE OF DEATH

06330

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY Montg. Co. Md Montgomery County General Hosp. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Md. Olney				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.				d. STREET ADDRESS Boyd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last George Phillip Smith Hoyle				4. DATE OF DEATH Month Day Year June 3 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27-1868	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller--Mfg. of flour flour (owner retiree)				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Thomas Hoyle				14. MOTHER'S MAIDEN NAME Jane Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mrs Smith Hoyle, Boyd, Md			
17. INFORMANT Mrs Smith Hoyle, Boyd, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Cardio Vascular DUE TO hemian (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Year Year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 15, 19 56 to June 3, 19 56 , that I last saw the deceased alive on June 3, 19 56 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jack Schumacher M.D. Smithsburg, Md. 6-3-56							
ACTUAL SIGNATURE Jack Schumacher							
PHYSICIAN'S NAME (Type) Jack Schumacher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/56		22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or county) (State) Boyd Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Wilson, Barnesville, Md				24a. REC'D BY REGISTRAR 6/4/56		24b. REGISTRAR'S SIGNATURE Charles W. Elgin for reg.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be re-executed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: **Monte, O. M.**
 SEX: **Male**
 AGE: **60**
 DATE OF BIRTH: **1896**
 PLACE OF BIRTH: **Italy**
 OCCUPATION: **General**

DECEASED'S ADDRESS: **1000 North Avenue, Baltimore, Md.**
 DECEASED'S PHONE: **1000**
 DECEASED'S RELIGION: **Catholic**
 DECEASED'S MARITAL STATUS: **Married**
 DECEASED'S EDUCATION: **High School**

DECEASED'S OCCUPATION: **General**
 DECEASED'S EMPLOYER: **General**
 DECEASED'S DATE OF DEATH: **June 10, 1956**
 DECEASED'S TIME OF DEATH: **10:00 AM**

DECEASED'S CAUSE OF DEATH: **Heart Failure**
 DECEASED'S MANNER OF DEATH: **Natural**
 DECEASED'S PLACE OF DEATH: **Home**
 DECEASED'S SIGNATURE: **John Thomas Hoxie**

DECEASED'S SIGNATURE: **John Thomas Hoxie**
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BUREAU V. S.

JUN 6 1956

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6353
CERTIFICATE OF DEATH

06331

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Jason Last Hoyle		4. DATE OF DEATH Month June Day 11 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/62
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hoyle		14. MOTHER'S MAIDEN NAME Jane Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Record (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Gen'l. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH In definite		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 11, 1956 , to June 11, 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED 6-12-56			
ACTUAL SIGNATURE Jack Schumacher M.D.		PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR DATE 6-14-56	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6354

CERTIFICATE OF DEATH

06332

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4609 Waverly Street</u>				d. STREET ADDRESS <u>4609 Waverly Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT SCOTT HUDGINS</u>				4. DATE OF DEATH Month Day Year <u>June 9, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2 27</u>		IF UNDER 24 HRS. Hours Min. <u>27</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Federal Houseng</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert S. Hudgins</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Schmelz</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Helen N. Hudgins-wife Item #2 Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO <u>anotemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 day</u> <u>4 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dietary</u> <u>Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Brookville, Mtg Co. Md</u>	
21. I certify that I attended the deceased from <u>6/9/56</u> , 19 <u>56</u> , to <u>6/9/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/9/56</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Allen</u>				DATE SIGNED <u>6-10-56</u>			
PHYSICIAN'S NAME (Type) <u>Samuel Allen</u>				ADDRESS (Street, city or town, state) <u>10407 Fawcett St., Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brookville, Mtg Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>10407 Fawcett St., Kensington, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6355
CERTIFICATE OF DEATH

06333

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center National Institutes of Health		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina b. COUNTY 90X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaufort d. STREET ADDRESS 1004 Ann Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Norma Louise Hunnings		4. DATE OF DEATH Month Day Year June 22 19 56	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 May 1922
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Parkin		14. MOTHER'S MAIDEN NAME Marguerite Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. not available	
17. INFORMANT Medical Record		Address Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelocytic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 12 hr 4 mos			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 June , 19 56 , to 22 June , 19 56 , that I last saw the deceased alive on 22 June , 19 56 , and that death occurred at 1.20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/22/56 ACTUAL SIGNATURE Arnold Flick M.D. PHYSICIAN'S NAME (Type) Arnold Flick, M. D. The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/56	
22c. NAME OF CEMETERY OR CREMATORY Ocean View		22d. LOCATION (City, town, or county) (State) Carteret Co., N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 6-23-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6293

CERTIFICATE OF DEATH

06334

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4829 No. Capitol	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7300 Balt. Ave.		d. STREET ADDRESS Washington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia E. Middle Ingels Last		4. DATE OF DEATH Month June Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1867
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George A. Buckey		14. MOTHER'S MAIDEN NAME Rebecca ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George B. Ingels		Address 4829 N. Cap. Was. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Senile) Myocardosis Congestive Heart Failure DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 55 , to June , 19 56 , that I last saw the deceased alive on June 12 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Richard J. Pross M.D. 4601 16th St N.W. Wash 11 D.C. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1956	
22c. NAME OF CEMETERY OR CREMATORY Williamsport		22d. LOCATION (City, town, or county) (State) Williamsport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. Wash: D.C.	
24a. REC'D BY REGISTRAR 6/9/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

NAME OF DECEASED George A. L. Jones		SEX Male		RACE White		DATE OF BIRTH Dec. 1, 1901		PLACE OF BIRTH Baltimore, Md.	
RESIDENCE 1200 E. 1st Ave.		OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH June 14, 1956	
PLACE OF DEATH Home		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF REGISTRAR [Signature]	
COUNTY Baltimore		CITY Baltimore		STATE Maryland		ZIP CODE 21201		REGISTRATION NO. 12345	

BUREAU V. 2

JUN 21 1956

RECEIVED

6356

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Silver Spring</u>		c. LENGTH OF STAY IN TB <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>S.</u> Last <u>Iredale</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1873</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk- Veterans Administration</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Orange Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Slaughter</u>		14. MOTHER'S MAIDEN NAME <u>Emma Thomam</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Mercer S. Wolfe</u>		Address <u>6510 5th St., N.W. Wash, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>55</u> , to <u>June 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>56</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>a. J. Kistler</u>		ADDRESS (Street, city or town, state) <u>6/2/56</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>A. J. Kistler, M.D.</u>		M.D. <u>Cedarcroft Sanitarium, Columbia Pike, S.S. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/4/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash, D.C.</u>	
24a. REC'D BY REGISTRAR <u>6/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6357

CERTIFICATE OF DEATH

06336

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 45 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First Middle Last Joines				Month Day Year June 18 19 56				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/56		
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.		45		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carlise Edison Joines				14. MOTHER'S MAIDEN NAME Nada Roberta Landreth				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address				
No		None		Hospital Record				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (Weight 1-9) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 19 56 , to June 18, 19 56 , that I last saw the deceased alive on June 18, 19 56 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE C. S. Whitaker M.D.								
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL			6-18-56		LINTHICUM CHAPEL		CLARKSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
F. HIGGINBOTHAM, ELICOTT CITY MD					DATE 6-21-56		Gertrude B. Taylor	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2273294XVO

CERTIFICATE OF DEATH

6857

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1/1/1910		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Place of Report	
10/1/56		10:00 AM		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]		10/1/56		New York City	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Date of Report		Place of Report		Signature of Registrar		Date of Report	
John Doe		Son		123 Main St		New York City		New York		10001		[Signature]		10/1/56		New York City		[Signature]		10/1/56	

BUREAU V. 3

UN 28 1956

RECEIVED

6358

CERTIFICATE OF DEATH

06337

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 8½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Joines				4. DATE OF DEATH Month Day Year June 18 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1956		9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carlise Edison Joines				14. MOTHER'S MAIDEN NAME Nada Roberta Landreth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (weight 1-6) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 1956 , to June 19, 1956 , that I last saw the deceased alive on June 19, 1956 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ch. Whiteaker M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-18-56		22c. NAME OF CEMETERY OR CREMATORY LUTHERICUM CHAPEL CLARKSVILLE MD		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 15616 IN BOLD OM, ELLIOT CITY MD				24a. REC'D BY REGISTRAR DATE 6-21-56		24b. REGISTRAR'S SIGNATURE Bertie B Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2173293XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF INTERMENT		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
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85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. B.

JUN 26 1956

RECEIVED

6359

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills				d. STREET ADDRESS - - - - -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNM, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Timothy Middle Lee Last JOLLY				4. DATE OF DEATH Month June Day 2 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 May 1956		9. AGE (In years last birthday) yrs. 29	IF UNDER 1 YEAR Months 29	IF UNDER 24 HRS. Hours 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elbert John JOLLY				14. MOTHER'S MAIDEN NAME Lola Irene JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Address Elbert John JOLLY Great Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration & Alkalosis 756.0 DUE TO Hypertrophic Pyloric Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 Days DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 May , 19 56 , to 2 June , 19 56 , that I last saw the deceased alive on 1 June , 19 56 , and that death occurred at 3:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USNH, NNM, Bethesda, Md. 2 June 1956							
ACTUAL SIGNATURE George J.A. Magnant M.D.				PHYSICIAN'S NAME (Type) George J.A. MAGNANT LT MC USN USNH, NNM, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-56		22c. NAME OF CEMETERY OR CREMATORY Meth. Ch. Great Mills, Md.		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R.H. PUMPHREY ADDRESS 7557 Wisc. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 6-2-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

1956 5 JUN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6360

CERTIFICATE OF DEATH

06339

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Kensington d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY -- 47X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3872 Porter Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Nell First H. Middle JONES Last		4. DATE OF DEATH Month June Day 14, Year 19 56						
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1878	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George M. Hubbard				14. MOTHER'S MAIDEN NAME Isabel Herndon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Isabel A. Stephens- Address 3872 Porter St. N.W.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) & Metastases to Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 11, 1956 , to June 14, 1956 , that I last saw the deceased alive on 6:00 PM 1956 , and that death occurred at 8:45 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Neil P. Campbell		M.D. Kennerly apt		ADDRESS (Street, city or town, state) Washington D.C.		DATE SIGNED June 14/56		
PHYSICIAN'S NAME (Type) Neil P. Campbell								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/56		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 6-18-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED George H. Thompson		2. SEX Male		3. AGE 65	
4. RACE White		5. BIRTH DATE 1911		6. BIRTH PLACE Maryland	
7. DECEASED DATE June 15, 1956		8. DECEASED TIME 10:30 AM		9. DECEASED PLACE Home	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED SYMPTOMS Chest pain, shortness of breath	
13. DECEASED SIGNATURE George H. Thompson		14. DECEASED ADDRESS 1234 Main St, Baltimore, MD		15. DECEASED CITY Baltimore	
16. DECEASED STATE Maryland		17. DECEASED ZIP 21201		18. DECEASED COUNTY Baltimore	
19. DECEASED DISTRICT Baltimore		20. DECEASED WARD Baltimore		21. DECEASED BLOCK Baltimore	
22. DECEASED LOT Baltimore		23. DECEASED TRACT Baltimore		24. DECEASED SUBDIVISION Baltimore	
25. DECEASED PARCEL Baltimore		26. DECEASED LOT Baltimore		27. DECEASED TRACT Baltimore	
28. DECEASED SUBDIVISION Baltimore		29. DECEASED PARCEL Baltimore		30. DECEASED LOT Baltimore	
31. DECEASED TRACT Baltimore		32. DECEASED SUBDIVISION Baltimore		33. DECEASED PARCEL Baltimore	
34. DECEASED LOT Baltimore		35. DECEASED TRACT Baltimore		36. DECEASED SUBDIVISION Baltimore	
37. DECEASED PARCEL Baltimore		38. DECEASED LOT Baltimore		39. DECEASED TRACT Baltimore	
40. DECEASED SUBDIVISION Baltimore		41. DECEASED PARCEL Baltimore		42. DECEASED LOT Baltimore	
43. DECEASED TRACT Baltimore		44. DECEASED SUBDIVISION Baltimore		45. DECEASED PARCEL Baltimore	
46. DECEASED LOT Baltimore		47. DECEASED TRACT Baltimore		48. DECEASED SUBDIVISION Baltimore	
49. DECEASED PARCEL Baltimore		50. DECEASED LOT Baltimore		51. DECEASED TRACT Baltimore	
52. DECEASED SUBDIVISION Baltimore		53. DECEASED PARCEL Baltimore		54. DECEASED LOT Baltimore	
55. DECEASED TRACT Baltimore		56. DECEASED SUBDIVISION Baltimore		57. DECEASED PARCEL Baltimore	
58. DECEASED LOT Baltimore		59. DECEASED TRACT Baltimore		60. DECEASED SUBDIVISION Baltimore	
61. DECEASED PARCEL Baltimore		62. DECEASED LOT Baltimore		63. DECEASED TRACT Baltimore	
64. DECEASED SUBDIVISION Baltimore		65. DECEASED PARCEL Baltimore		66. DECEASED LOT Baltimore	
67. DECEASED TRACT Baltimore		68. DECEASED SUBDIVISION Baltimore		69. DECEASED PARCEL Baltimore	
70. DECEASED LOT Baltimore		71. DECEASED TRACT Baltimore		72. DECEASED SUBDIVISION Baltimore	
73. DECEASED PARCEL Baltimore		74. DECEASED LOT Baltimore		75. DECEASED TRACT Baltimore	
76. DECEASED SUBDIVISION Baltimore		77. DECEASED PARCEL Baltimore		78. DECEASED LOT Baltimore	
79. DECEASED TRACT Baltimore		80. DECEASED SUBDIVISION Baltimore		81. DECEASED PARCEL Baltimore	
82. DECEASED LOT Baltimore		83. DECEASED TRACT Baltimore		84. DECEASED SUBDIVISION Baltimore	
85. DECEASED PARCEL Baltimore		86. DECEASED LOT Baltimore		87. DECEASED TRACT Baltimore	
88. DECEASED SUBDIVISION Baltimore		89. DECEASED PARCEL Baltimore		90. DECEASED LOT Baltimore	
91. DECEASED TRACT Baltimore		92. DECEASED SUBDIVISION Baltimore		93. DECEASED PARCEL Baltimore	
94. DECEASED LOT Baltimore		95. DECEASED TRACT Baltimore		96. DECEASED SUBDIVISION Baltimore	
97. DECEASED PARCEL Baltimore		98. DECEASED LOT Baltimore		99. DECEASED TRACT Baltimore	
100. DECEASED SUBDIVISION Baltimore		101. DECEASED PARCEL Baltimore		102. DECEASED LOT Baltimore	

RECEIVED
JUN 20 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06340

6361

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Michigan</u> b. COUNTY <u>59X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		c. LENGTH OF STAY IN 1b <u>1 mo 1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>211 Pleasant Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hans</u> Middle <u>Emil</u> Last <u>KARDEL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-96</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of State</u>	
11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Hans KARDEL</u>		14. MOTHER'S MAIDEN NAME <u>Margaret STROBECH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife Mrs. Karen M. KARDEL</u> <u>Same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm, malignant, with multiple metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 May</u> , 19 <u>56</u> , to <u>21 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21 June</u> , 19 <u>56</u> , and that death occurred at <u>1:10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. L. Gerber</u>		DATE SIGNED <u>USNH, NNMC, Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>M. L. GERBER CAPT MC USN</u>		<u>USNH, NNMC, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>25 Jun 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte, Michigan</u>	
23. FUNERAL DIRECTOR'S NAME (Type) <u>7557 Wisconsin Avenue, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>21 Jun 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parody</u>	

JUN 25 1956

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6362
CERTIFICATE OF DEATH

06341

Reg. Dist. No. **211**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Purdum c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Purdum, Md. d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edward Walter King				4. DATE OF DEATH Month June Day 1 Year 1956											
5. SEX Male		6. COLOR OR RACE White		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-69		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Purdum, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Edward King						14. MOTHER'S MAIDEN NAME Julia Ann Budette									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No		17. INFORMANT XXXXX Son John King Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 10 years (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Aug. 10, 1947 to June 1, 1956 that I last saw the deceased alive on June 1, 1956 and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kern M.D. Hamascus, Md. DATE SIGNED 6/7/56 PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/4/56		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery				22d. LOCATION (City, town, or county) Pudum, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber						ADDRESS 139		24a. REC'D BY REGISTRAR DATE June 6/5-6		24b. REGISTRAR'S SIGNATURE Della W. Burdette					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

T. F. Elston

25-5-2

2

BUREAU

956T 8 NNC

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6363

CERTIFICATE OF DEATH

06342

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY 83x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. LENGTH OF STAY IN 1b 22 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle		d. STREET ADDRESS #10 Purvis Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle (n) Last KOVALUK Jr.		4. DATE OF DEATH Month June Day 28 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-56
9. AGE (In years last birthday) yrs. 4 Months 15 Days 15 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Michael (n) KOVALUK	
14. MOTHER'S MAIDEN NAME Janet Louise WORTMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. - -		17. INFORMANT Father Michael (n) KOVALUK Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 mos 15 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 June , 19 56 , to 28 June , 19 56 , that I last saw the deceased alive on 28 June , 19 56 , and that death occurred at 11:05 PM , from the causes and on the date stated above. George J. A. Magnant ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda, Maryland DATE SIGNED George J. A. MAGNANT LT MC USN M.D. USNH, NNMC, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5 Jul 1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Maryland		24a. REC'D BY REGISTRAR 29 Jun 1956 24b. REGISTRAR'S SIGNATURE Harry E. Parselley	

CERTIFICATE OF DEATH

PLACE IN SPACE FOR PHOTOGRAPH	
NAME OF DECEASED	
AGE	
SEX	
DATE OF BIRTH	
PLACE OF BIRTH	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION	
PLACE OF REGISTRATION	
OFFICIAL USE	
REMARKS	

BUREAU V. M.

JUL 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06343

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNH, NNM, BETHESDA, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4810 47th Street, NW			
3. NAME OF DECEASED (Type or print) First David Middle James Last LANEHART, Jr.				4. DATE OF DEATH Month June Day 10 Year 1956			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Sept. 1896	
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 10 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME David James LANEHART				14. MOTHER'S MAIDEN NAME Kathryn GETTNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-2 577 40 5420		17. INFORMANT Mrs. Mary E. LANEHART (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 600.0 IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ADENOMA OF PITUITARY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENOMA OF PITUITARY				INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes 1-2 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. BROSCART, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES				24a. REC'D BY REGISTRAR DATE 6-11-56			
24b. REGISTRAR'S SIGNATURE Bray C. Carrelly							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to cremation or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6294

CERTIFICATE OF DEATH

06344

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>602 Northampton Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beetha</u> Middle <u>Linden</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 2, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Clay Pardue</u>				14. MOTHER'S MAIDEN NAME <u>Malvinia Peeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Joseph Milton Hayes</u> Address <u>602 Northampton Dr Silver Springs Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis Thrombosis</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO <u>16 days</u> (c) <u>Arterio Sclerotic Heart Disease</u> <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>4:20</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1956</u> to <u>June 20, 1956</u> that I last saw the deceased alive on <u>June 4, 1956</u> , and that death occurred at <u>4:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis X. Richardson</u> M.D.				ADDRESS (Street, city or town, state) <u>7717 Alameda Rd</u>		DATE SIGNED <u>6/20/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS X. RICHARDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>6/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WEST VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SWEETWATER, MONROE CO., TENN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey, Inc S.S., Md.</u>				ADDRESS <u>2434 54 Ave</u>		24a. REC'D BY REGISTRAR DATE <u>6/22/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. H. H. H.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 26 1956

RECEIVED

6365

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>832-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>146 Garfield Estates</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Gregory</u> Last <u>Lester</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1954</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor Child</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Paul Lester</u>				14. MOTHER'S MAIDEN NAME <u>Betty Henley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>congenital heart disease - transposition</u> <u>7543</u> DUE TO <u>patent foramen ovale</u> <u>post operative</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Life</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 9</u> , 19 <u>56</u> , to <u>June 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Kenneth Magee</u> M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Kenneth Magee</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661-16th St NE Washington DC</u>				24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Hearn</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6366

CERTIFICATE OF DEATH

Reg. Dist. No.

06346

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>225 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u>		d. STREET ADDRESS <u>8001 Eastern Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>(None)</u> Last <u>Lichterman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 March 1892</u>
9. AGE (In years last birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lichterman</u>		14. MOTHER'S MAIDEN NAME <u>Naomi Liebermann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>243-24-3034</u>	
17. INFORMANT <u>The medical record</u>		Address <u>The Clinical Center Bethesda 14, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of breast, extensive metastases</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 8</u> , 19 <u>55</u> , to <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>56</u> , and that death occurred at <u>4:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mehran Gouljian</u>		M.D. <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Mehran Gouljian, M.D.</u>		DATE SIGNED <u>6/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew Cong. D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gregory James</u>		ADDRESS <u>4217-9th Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE 6-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1890		BALTIMORE		MD		USA		USA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1915		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
LABORER		1940		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1956		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1956		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1956		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1956		BALTIMORE		MD		USA		USA		JUN 10 1956		BALTIMORE		MD	

BUREAU V. 2

JUN 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6295

CERTIFICATE OF DEATH

Reg. Dist. No.

06348
223

NOTIFIED AND APPROVED BY MONTGOMERY COUNTY MEDICAL EXAMINER

DR. FRANK J. BROSCART

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X.3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>		d. STREET ADDRESS <u>1309 Floral</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Alice</u> Last <u>Lowe</u>		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 17, 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WOODRUF, SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DR. TRAPIER HENDERSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN GAINES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. JAMES T. LOWE, 1810 SUDBURY RD., N.W. WASHINGTON, D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured right femur and humerus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11</u> <u>6</u> <u>16</u> <u>1956</u> Hour <u>a.m.</u> <u>p.m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Washington</u> (County) <u>DC</u> (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>6/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>56</u> , and that death occurred at <u>3 p</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Franks</u>		ADDRESS (Street, city or town, state) <u>901 20th NW, Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Maurice Franks, M.D.</u>		DATE SIGNED <u>6/20/56</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Attorney C. Pumphrey</u>		24. REC'D BY REGISTRAR <u>JUN 23 1956</u>	
25. ADDRESS <u>SILVER SPRING, MD.</u>		26. REGISTRAR'S SIGNATURE <u>J. William Dood</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06349

6357

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3940 Washington St</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Galen</u> Last <u>Lull</u>		4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-74</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Educator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teachers College</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Franklin Lull</u>		14. MOTHER'S MAIDEN NAME <u>ELLA J DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Harriet L. C. Pepper</u>		Address <u>3940 Wash. St. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Rt. Carotid Artery Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-23</u> , 19 <u>56</u> , to <u>6-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-31</u> , 19 <u>56</u> , and that death occurred at <u>2:29 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10644 Connecticut Ave. Kensington, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		DATE SIGNED <u>6-1-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>6-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bonnie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6368

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>56 Silver Spring</u>		RURAL LENGTH OF STAY (in this place) <u>5 1/3 yrs</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>56 Silver Spring, Md</u>		RURAL LENGTH OF STAY (in this place) <u>5 1/3 yrs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>709 DRYDEN STREET</u>				STREET ADDRESS (If rural give location) <u>709 DRYDEN STREET</u>			
3. NAME OF DECEASED: (First) <u>BARBARA</u> (Middle) <u>LEE</u> (Last) <u>LYMAN</u>				4. DATE OF DEATH: (Month) <u>June</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX: <u>F.</u>	5. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>CHILD</u>	8. DATE OF BIRTH: <u>27 MARCH 1948</u>	9. AGE last birthday: <u>8</u> yrs.	IF UNDER 1 YEAR: Months <u>27</u> Days <u>27</u> Hours <u>19</u> Min. <u>56</u>		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>CHILD.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>LAWRENCE LYMAN</u>				14. MOTHER'S MAIDEN NAME: <u>ISABELLE HEWLETT.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>PARENTS - SAME.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
180X Immediate cause (a) <u>INANITION & EXHAUSTION,</u>				<u>1 MO.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>METASTATIC MALIGNANCY,</u>				<u>5 MOS.</u>	
(c) <u>WILMS TUMOR OF KIDNEY, LEFT</u>				<u>3 1/3 YRS.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE.</u>					
19a. DATE OF OPERATION: <u>13 MARCH 1953</u>		19b. MAJOR FINDINGS OF OPERATION: <u>WILMS TUMOR, LEFT KIDNEY; HORSERIDE KIDNES</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u></u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u></u>	
22. I hereby certify that I attended the deceased from <u>11 March 1953</u> , to <u>27 June 1956</u> , that I last saw the deceased alive on <u>23 June 1956</u> , and that death occurred at <u>4:02 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Josephine R. Rorick M.D.</u> ADDRESS <u>7309 Biggs Road W. Hyattsville Md.</u> DATE SIGNED <u>6/27/56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-27-56</u>		REGISTRAR'S SIGNATURE <u>Francesa Teller</u>		24. FUNERAL DIRECTOR ADDRESS <u>Deaf Francesa Home 4812 St. Ave Wash DC</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 29 1956

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6369
CERTIFICATE OF DEATH

06351

Reg. Dist. No. **217**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Chronic Hosp.				d. STREET ADDRESS 610 Bennington Dr.			
3. NAME OF DECEASED (Type or print) Booton Jackson Martin				4. DATE OF DEATH June 24 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12, 31, 1882	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station		10b. KIND OF BUSINESS OR INDUSTRY Springfield		11. BIRTHPLACE (State or foreign country) Front Royal, Va.		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Dudley Martin				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT John D. Martin Address Silver Spring Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Diabetes Insipidus + Dehydration DUE TO Lesion Sella Turcica DUE TO Dent. art. Sclerosis + Scurvy DUE TO 260 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 days 2 yrs 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 56 , to 6-24 , 19 56 , that I last saw the deceased alive on 6-24 , 19 56 , and that death occurred at 8:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Bosley Zeigler M.D.				ADDRESS (Street, city or town, state) Olney, Md			
PHYSICIAN'S NAME (Type) John Bosley Zeigler				DATE SIGNED 25 June 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun 26 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		22d. LOCATION (City, town, or county) (State) Cinnopolis 1119	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber ADDRESS Logtown Md				24a. REC'D BY REGISTRAR DATE 6-25-56		24b. REGISTRAR'S SIGNATURE Gertrude B Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 28 1956

BUREAU V. S.

DATE
TIME
PLACE
CAUSE OF
PART
CONDITIONS
NOTES
SIGNATURE
OFFICIAL

MEDICAL EXAMINER: This certificate should be executed
certificate, writing the word "pending" in pencil in Item 18;
d to the Chief Medical Examiner's Office along with form P-1
MAL DIRECTOR: Page 3 should be used as a burial-transit perm-
val.

necessary, please see
for. Page 4 should be
for to burial, cremation,
val.

5M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807381
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2603 Fenimore Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
f. STREET ADDRESS 2603 Fenimore Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLYDE ERNEST MARTIN, JR.		4. DATE OF DEATH Month June Day 25 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Crusty Pie Company Roanoke, Va.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest Martin, Sr.		14. MOTHER'S MAIDEN NAME Ruby Rucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WW #2		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mrs. Goldie M. Martin, 2603 Fenimore St., SS.Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Ascending Aorta by bullet. DUE TO (b) _____ (c) _____ gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was playing with gun - fired accidentally - when climbing	
20c. TIME OF INJURY Month, Day, Year 7:45 p.m. 6/25 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring mont. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/28/56	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR 7/5/56	
ADDRESS SILVER SPRING, MARYLAND		24b. REGISTRAR'S SIGNATURE Frances Ball	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 9 1956
BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06352

6370

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
c. LENGTH OF STAY in 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #27, Damascus, Maryland		d. STREET ADDRESS Route #27	
3. NAME OF DECEASED (Type or print) First Carol-Jane Middle Mattes Last Mattes		4. DATE OF DEATH Month June Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1946
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LeClaire Mattes		14. MOTHER'S MAIDEN NAME Jane Hinds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pinealoma operated upon Sept 55 followed by X-ray DUE TO 272X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Necrosis of and possibly tumor of DUE TO (c) pituitary and hypothalamus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 28, 1955 , to April 24, 1956 , that I last saw the deceased alive on April 24, 1956 , and that death occurred at 9:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard D. Fritz M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Richard D. Fritz		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 7, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Michaels	22d. LOCATION (City, town, or county) (State) Poplar Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molsworth ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE June 6/5-6	24b. REGISTRAR'S SIGNATURE Della W. Burdell

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BUREAU

1956 8 JUN

RECEIVED

6371

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 10001 George Avenue							
3. NAME OF DECEASED (Type or print) First William Middle McClure Last McClure				4. DATE OF DEATH Month June Day 25 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/23/83	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Col. Charles McClure				14. MOTHER'S MAIDEN NAME Annie Getty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Broncho-Pneumonia DUE TO (c) Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
INTERVAL BETWEEN ONSET AND DEATH 26 days 6 days ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/8/56 to 6/25/56 , that I last saw the deceased alive on 6/25/56 , 19 56 , and that death occurred at 3:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird, M. D.				DATE SIGNED 6-27-56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/27/56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR 6-27-56		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06354

6296

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>			
c. LENGTH OF STAY IN 1b <i>16 hrs</i>				d. STREET ADDRESS <i>6807 Riggs Rd</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash San + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MC Coy</i>				4. DATE OF DEATH Month Day Year <i>6 30 1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 29, 1956</i>	
9. AGE (In years last birthday) yrs. <i>16</i>		IF UNDER 1 YEAR Months Days Hours Min. <i>16 00</i>		IF UNDER 24 HRS. <i>16 00</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>John Rolfe Mc Coy</i>				14. MOTHER'S MAIDEN NAME <i>Louise Schut Z</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Secondary Anoxia</i> 762.5 DUE TO <i>atelectasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prematurity - 29 weeks.</i> (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 29, 1956</i> to <i>June 30, 1956</i> , that I last saw the deceased alive on <i>June 29, 1956</i> , and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Taul Eavey</i> M.D. <i>6727-16th SA 7-9-16-30-56</i>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>TAUL EAVEY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>				22b. DATE THEREOF <i>7-1-56</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium</i>				22d. LOCATION (City, town, or county) (State) <i>Takoma Park, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M.D., Washington Sanitarium</i>				24a. RECEIVED BY REGISTRAR DATE <i>July 2 1956</i>			
				24b. REGISTRAR'S SIGNATURE <i>J. H. H. R. D. V.</i>			

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RECEIVED

JUL 6 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6372

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 WKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
3. NAME OF DECEASED (Type or print) JESSIE First IVA Middle MCENTEE Last		4. DATE OF DEATH 6 Month 4 Day 1956 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-96
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 60 Days 60 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENO-CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT E. VERNON		14. MOTHER'S MAIDEN NAME ALICE O. O'KELLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-44-8957	
17. INFORMANT SON - WALES C. VERNON		Address 3401 KENSINGTON-WHEATON RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ABDOMINAL CARCINOMATOSIS DUE TO 1MO (c) CARCINOMA OF COLON 10 MO.		INTERVAL BETWEEN ONSET AND DEATH 12 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 1955, to JUNE 1956 that I last saw the deceased alive on JUNE 4 1956, and that death occurred at 8:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 921-20th St N.W. DATE SIGNED 6/4/56			
ACTUAL SIGNATURE Garnet W. Ault M.D.		PHYSICIAN'S NAME (Type) GARNET W. AULT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR 6-5/56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. R.

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RECEIVED
1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6306

CERTIFICATE OF DEATH

06356

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 515 Beall Ave.				d. STREET ADDRESS 515 Beall Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LADUE Middle E. Last McGILL				4. DATE OF DEATH Month June Day 13 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 25		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Minister		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George E. McGill				14. MOTHER'S MAIDEN NAME Laura V. King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Howard F. Cundiff - Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis (c) Hypertension + arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yrs. Indef					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11/1957 , to 6/13/1956 , that I last saw the deceased alive on 6/13/1956 , and that death occurred at 8:02 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen D. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 6/14/56			
PHYSICIAN'S NAME (Type) Stephen Jones				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 6/18/56	
				24b. REGISTRAR'S SIGNATURE Samuel Kratoch			

CERTIFICATE OF DEATH

MONTGOMERY		MONTGOMERY	
ROCKVILLE		ROCKVILLE	
112 Beall Ave.		112 Beall Ave.	
E. MCGILL		E. MCGILL	
JUNE 12		JUNE 12	
MAY 10, 1957		MAY 10, 1957	
WHITE		WHITE	
MAY 10, 1957		MAY 10, 1957	
WASHINGTON, D.C.		WASHINGTON, D.C.	
Church		Church	
George E. McGill		George E. McGill	
Howard E. Cunniff - Item 2		Howard E. Cunniff - Item 2	
Yes		Yes	
No		No	

BUREAU V. S.

JUN 28 1956

RECEIVED

STEPHEN JONES		STEPHEN JONES	
ROCKVILLE, MARYLAND		ROCKVILLE, MARYLAND	
JUNE 12		JUNE 12	
MAY 10, 1957		MAY 10, 1957	
WHITE		WHITE	
MAY 10, 1957		MAY 10, 1957	
WASHINGTON, D.C.		WASHINGTON, D.C.	
Church		Church	
George E. McGill		George E. McGill	
Howard E. Cunniff - Item 2		Howard E. Cunniff - Item 2	
Yes		Yes	
No		No	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6373

CERTIFICATE OF DEATH

Reg. Dist. No.

06357

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 46 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center, Nat'l. Inst. of Health		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 838-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 1215 Powhatan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Teresa Middle Lee Last Mills		4. DATE OF DEATH Month June Day 22 Year 19 56					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Dec. 1952	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Mills			14. MOTHER'S MAIDEN NAME Nancy VanHynning				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address Clinical Center, National Inst. of Health, Bethesda			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcomia - Stomach Anemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia L. Lung + Massive Hemorrhage 1 wk. DUE TO (c) Acute lymphocytic leukemia 2 yrs						INTERVAL BETWEEN ONSET AND DEATH Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May, 1956 , to 22 June, 1956 , that I last saw the deceased alive on 22 June, 1956 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Emil J. Freireich		M.D.		DATE SIGNED 6/22/56			
PHYSICIAN'S NAME (Type) Emil J. Freireich, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-56		22c. NAME OF CEMETERY OR CREMATORY Mt Comfort		22d. LOCATION (City, town, or county) (State) Fairfax Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home Inc. Alexandria, Va.			ADDRESS		24a. REC'D BY REGISTRAR DATE 6-26-56		24b. REGISTRAR'S SIGNATURE Bessie Mc Thompson

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

BUREAU V. S.

82 JUN 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07395

6374

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14708 Newport Mill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Ann Minogue</u>				4. DATE OF DEATH <u>June 30 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-54</u>	
9. AGE (in years last birthday) <u>12</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>John Minogue</u>				14. MOTHER'S MAIDEN NAME <u>Mary Logan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>John Minogue - Same as Sister</u>			
17. INFORMANT <u>John Minogue - Same as Sister</u>				Address <u>14708 Newport Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>571.0</u> DUE TO <u>Acute gastroenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>14 hrs</u> DUE TO (c) <u>14 hrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-2-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>				22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				24a. REC'D BY REGISTRAR <u>7/5/56</u>			
ADDRESS <u>3821-14th St. NW, Wash. D.C.</u>				24b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>			

MEDICAL CERTIFICATION

RECEIVED
JUL 9 1956
BUREAU V. 3

6375

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		d. STREET ADDRESS COLESVILLE RD., R.F.D.#1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle W. Last MULLIGAN		4. DATE OF DEATH Month JUNE Day 12 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 17, 1877
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM HAND		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAY		14. MOTHER'S MAIDEN NAME ALICE GATES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-24-2924	
17. INFORMANT Address Mrs. Raymond Burriss, Colesville Rd., R.F.D.#1 Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus & tracheoesophageal fistula DUE TO (b) 1 year DUE TO (c) 2 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-27, 1956 , to 6-12, 1956 , that I last saw the deceased alive on 6-11, 1956 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason Geiger		ADDRESS (Street, city or town, state) 931 Pershing Drive Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		DATE SIGNED 6-12-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/14/56	22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 6-14-56	24b. REGISTRAR'S SIGNATURE Mary Harrelly

BUREAU V. 3

JUN 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06359

6376

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brookmont (Washington 16 DC)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp. Bethesda</u>				STREET ADDRESS (If rural give location) <u>6020 Broad Street</u>			
3. NAME OF DECEASED (Type or Print) <u>MYRTLE ARLENE MUNSEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 10, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-3-1906</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leroy Smith</u>				14. MOTHER'S MAIDEN NAME <u>Grace Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-48-0130</u>		17. INFORMANT & ADDRESS <u>Ernest L. Munsey-Husband-Add. Item 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
197X IMMEDIATE CAUSE (A) <u>Generalized sarcomatosis,</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>from LEIOMYOSARCOMA uterus</u>						<u>9 mo.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>With metastasis to kindeys, lungs and</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>anterior abdominal wall, and numerous skin nodules.</u>							
19a. DATE OF OPERATION <u>Oct. 17, 1955 and April 13, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Oct. 55- B above Abdominal Meastastasis to wall</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, Of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 12, 1955</u> to <u>June 10, 1956</u> , that I last saw the deceased alive on <u>June 10, 1956</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. SIGNATURE <u>C. P. Ryland</u> ADDRESS (Street, city, town, state) <u>4400 49th St. N.W.</u> DATE SIGNED <u>6-10-56</u> M.D. <u></u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
24. REC'D BY REGISTRAR DATE <u>6-11-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of death (Month, Day, Year)

5. Time of death (Hour and Minute)

6. Place of death (City, State, and Country)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Signature of attending physician

11. Signature of medical examiner

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of health officer

17. Signature of coroner

18. Signature of jury

19. Signature of jury

20. Signature of jury

21. Signature of jury

22. Signature of jury

23. Signature of jury

24. Signature of jury

25. Signature of jury

26. Signature of jury

27. Signature of jury

28. Signature of jury

29. Signature of jury

30. Signature of jury

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41. Signature of jury

42. Signature of jury

43. Signature of jury

44. Signature of jury

45. Signature of jury

46. Signature of jury

47. Signature of jury

48. Signature of jury

BUREAU V. 3

JUN 13 1956

RECEIVED

6297

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ----- b. COUNTY -----			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery Takoma Park				c. LENGTH OF STAY IN 1b 15 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 844 Jefferson St. N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ethel Middle Virginia Last Murphy		4. DATE OF DEATH Month June Day 8 Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-82	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Windham				14. MOTHER'S MAIDEN NAME Annie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-23- , 19 56 , to 6-8-56 , 19 56 , that I last saw the deceased alive on 6-7-56 , 19 56 , and that death occurred at 7:15 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur E. Coyne				ADDRESS (Street, city or town, state) 7600 Carroll Ave Takoma Park			
PHYSICIAN'S NAME (Type) Arthur E. Coyne				DATE SIGNED 6-8-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/56		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 6-11-56	
				24b. REGISTRAR'S SIGNATURE J. Walter Dodd			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5293

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06361

6377

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		56	
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>9822 Woodland Drive</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HANNAH M. NESLINE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 21 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 9, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Sangbein</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Goetz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Dorothy Nesline 9822 Woodland Drive</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cerebral arteriosclerosis</u>						<u>15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>essential hypertension</u>						<u>25 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 42</u> , 19 <u>56</u> to <u>6-29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6-29</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel M. Baggett</u>				DATE SIGNED <u>6/29/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Frances Gatter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geier Funeral Home</u>		ADDRESS <u>3605-14 NW Wash D.C.</u>	
DATE <u>6/30/56</u>							

CERTIFICATE OF DEATH

5037

Reg. Dist. No.

STATE OF MARYLAND, COUNTY OF BALTIMORE

NAME OF DECEASED	DATE OF DEATH
PLACE OF DEATH	AGE AT DEATH
SEX	CAUSE OF DEATH
EDUCATION	DATE OF BIRTH
RELIGION	PLACE OF BIRTH
OCCUPATION	DATE OF DEATH
RESIDENCE	DATE OF DEATH

NAME OF DECEASED: **MANUEL M. WESLINE**

DATE OF DEATH: **1937**

PLACE OF DEATH: **1017**

AGE AT DEATH: **1937**

SEX: **1937**

EDUCATION: **1937**

RELIGION: **1937**

OCCUPATION: **1937**

RESIDENCE: **1937**

DATE OF DEATH: **1937**

DATE OF DEATH: **1937**

DATE OF DEATH: **1937**

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DATE OF DEATH: **1937**

BUREAU A. E.

JUL 5 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film 199 6-25-56 et

6378

CERTIFICATE OF DEATH

Reg. Dist. No.

06362

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Montgomery Maryland Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sumner		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sumner	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4906 Brookway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Amos Last O'Neal		4. DATE OF DEATH Month 6-17 Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1899
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Public Relations	
11. BIRTHPLACE (State or foreign country) Blackwater, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sanford Alonzo O'Neal		14. MOTHER'S MAIDEN NAME Sarah Agnes Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Samuel O'Neal, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Lung, Right DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 YR.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1956 , to June 17, 1956 , that I last saw the deceased alive on June 17, 1956 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Conn. Ave. WASH. D.C. DATE SIGNED 6/17/56			
ACTUAL SIGNATURE William T. Saccardi M.D.		PHYSICIAN'S NAME (Type) WILLIAM T. SACCARDI 1150 Conn Ave WASH. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-19-56	
22c. NAME OF CEMETERY OR CREMATORY OLD LAMINE		22d. LOCATION (City, town, or county) (State) BOONVILLE MO.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Miller Sons		ADDRESS 1756 Pa. Ave. NW. D.C.	
24a. REC'D BY REGISTRAR 6-19-56		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

CERTIFICATE OF DEATH

4900 Broadway Drive		4900 Broadway Drive	
Samuel Amos O'Neal		Samuel Amos O'Neal	
Sept. 18, 1909		Sept. 18, 1909	
Public Relations		Public Relations	
Baltimore, No. 1, USA		Baltimore, No. 1, USA	
Samuel Amos O'Neal		Samuel Amos O'Neal	
Mrs. Samuel O'Neal, Same		Mrs. Samuel O'Neal, Same	
Bureau V. 2		Bureau V. 2	
JUN 21 1956		JUN 21 1956	
RECEIVED		RECEIVED	
1700 Pe. Ave. N.W. D.C.		1700 Pe. Ave. N.W. D.C.	

6379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		c. LENGTH OF STAY IN 1b 14 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1518 DALE DRIVE	
d. STREET ADDRESS 1518 DALE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last O'SHAUGHNESSY		4. DATE OF DEATH Month JUNE Day 12 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/86
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF OF REPRODUCTION U.S. GOV'T.		10b. KIND OF BUSINESS OR INDUSTRY ARMY MAP SERVICE	11. BIRTHPLACE (State or foreign country) NEW YORK CITY, NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN O'SHAUGHNESSY	
14. MOTHER'S MAIDEN NAME CATHERINE FLANNAGAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. YES		17. INFORMANT Address Mrs. Minerva E. O'Shaughnessy, 1518 Dale Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Lower Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malnutrition DUE TO (c) malnutrition		INTERVAL BETWEEN ONSET AND DEATH 34 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11 , 19 56 , to 6/12 , 19 56 , that I last saw the deceased alive on 6/12 , 19 56 , and that death occurred at 5:38 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE N. T. Lucius		ADDRESS (Street, city or town, state) 9321 Georgia Ave DATE SIGNED 6/13/56	
PHYSICIAN'S NAME (Type) N. T. LUCIUS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/15/56	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 6/19/56 24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06364

6380

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN lb 8 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8707 Maywood Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle COCHRANE Last Parr				4. DATE OF DEATH Month June Day 14 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1870	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Harpers Ferry, W.Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME W. W. Cochrane				14. MOTHER'S MAIDEN NAME Mary D. Beale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dorothy Terango, 8707 Maywood Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of bowel - metast. to lung DUE TO (c) ---				INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 11, 1956 , to June 13, 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at 7 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sanford J. Randall M.D. 3636 16 ST. N.W. D.C.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) SANFORD J. RANDALL, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gamble's Sons				ADDRESS 1756 Pa. Ave., N.W.,		24a. REC'D BY REGISTRAR 4/7/56	
				24b. REGISTRAR'S SIGNATURE James Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 21 1956

RECEIVED

CERTIFICATE OF DEATH

06365

Reg. Dist. No. 215

6331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. H.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 4106 7th Street	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last PERO		4. DATE OF DEATH Month June Day 16 Year 18, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-56
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Matthew PERO Jr.		14. MOTHER'S MAIDEN NAME Sylvia G. SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Father Mr. Matthew PERO Jr.		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 June , 19 56 , to 18 June , 19 56 , that I last saw the deceased alive on 18 June , 19 56 , and that death occurred at 2:10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, NMMC, Bethesda, Maryland DATE SIGNED _____ ACTUAL SIGNATURE _____ PHYSICIAN'S NAME (Type) H.A. PEARSON LT MC USNR USNH, NMMC, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 21 June 1956	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery v	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Gaschs Funeral Home		24a. REC'D BY REGISTRAR DATE 19 Jun 1956	
ADDRESS 4739 Baltimore Avenue, Hyattsville, Maryland		24b. REGISTRAR'S SIGNATURE W. G. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

F. Gasch's Sons - 205/191 XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06366

6382

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Forrestville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francis Middle Xavier Last PETTIT				4. DATE OF DEATH Month June Day 2 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 January 1936	
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 20 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Months 20 Days 2 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Student			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert Francis PETTIT				14. MOTHER'S MAIDEN NAME Katherine WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Katherine WOLFE PETTIT				Address 5832 Ritchie Road Forrestville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxis 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malignant melanoma DUE TO (c) 5 mond. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 mond. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3 May , 19 56 , to 2 June , 19 56 , that I last saw the deceased alive on 2 June , 19 56 , and that death occurred at 5:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH, NNMC, BETHESDA, MD. DATE SIGNED 3 June 1956							
ACTUAL SIGNATURE M.B. Sullivan, Jr. M.D. USNH, NNMC, BETHESDA, MD.							
PHYSICIAN'S NAME (Type) M.B. SULLIVAN, Jr. LT MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 JUNE 1956		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE J.T. RYAN Funeral Home				24a. REC'D BY REGISTRAR 317 Penn. Ave. Washington, D.C.			
24b. REGISTRAR'S SIGNATURE Barry E. Parrelly							

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>DATE OF REPORT [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	

BUREAU V. S.

JUN 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

6383 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06367
Reg. Dist. No. 214

Items 4, 13, 14, 17: film G200 7-23-56 L

6383 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X 3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS</u>		d. STREET ADDRESS <u>2008 38th St SE</u>	
3. NAME OF DECEASED (Type or print) <u>Elsie T. Phillips</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-96</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Albany NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward T. TICE</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ferris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2008 38th St SE</u>	
17. INFORMANT <u>Jersey Phillips</u>		Address <u>SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>CARCINOMA OF STOMACH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. Lawton Thompson M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) _____		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-2-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Swicland Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deale Funeral Home</u>		ADDRESS <u>41812 2nd Ave NE</u>	
24a. REC'D BY REGISTRAR <u>6/6/56</u>		DATE <u>6/6/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24c. REGISTRAR'S SIGNATURE _____	

BUREAU V. S.

JUL 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06368

6384

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Liber, Sp.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Liber, Sp.</u>	
TOWN <u>Liber, Sp.</u>		TOWN <u>Liber, Sp.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1021 Ruston St.</u>		STREET ADDRESS (If rural, give location) <u>1021 Ruston St.</u>	
3. NAME OF DECEASED (Type or Print) <u>BLANCHE M. PLYER</u>		4. DATE OF DEATH <u>June 26 1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Dec 12 - 1880</u>	
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never employed</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Pleyer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Moffett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>1914 N. Arlington St. Del. DE</u>	
17. INFORMANT AND ADDRESS <u>Hazel Harward</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X Immediate cause

(a) Carcinoma of the right lung with metastasis.

INTERVAL BETWEEN ONSET AND DEATH

about 4 mo.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 7, 1956, to June 26, 1956, that I last saw the deceased alive on June 25, 1956, and that death occurred at 8:10 a.m., from the causes and on the date stated above.

SIGNATURE Walter K. Angervine, M.D. 6300-13th St. N.W., Wash. D.C. DATE SIGNED June 26, 1956

23. BURIAL CREMATION REMOVAL (Specify) June 28, 1956 NAME OF CEMETERY OR CREMATORY Rock Creek Cem LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG 6/26/56 REGISTRAR'S SIGNATURE Francis J. Miller 24. FUNERAL DIRECTOR St. James Co. ADDRESS 2901 14th St. N.W., Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

JUN 28 1956

BUREAU V. A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385

CERTIFICATE OF DEATH

06369

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5800 L. Avenue NW</u>	
3. NAME OF DECEASED (Type or print) First <u>STEINER</u> Middle <u>Jo.</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter Retired Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William S. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Hallie S. Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Walter B. Powell</u>		Address <u>240 Culington Village</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.1</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated duodenal ulcer</u> DUE TO <u>3 weeks</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>56</u> , to <u>6/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/3</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville Md</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>J. H. McCarrick</u> M.D.		DATE SIGNED <u>6-5/56</u>	
PHYSICIAN'S NAME (Type) <u>J. H. McCarrick MD</u>		ADDRESS <u>809 Viers Mill Rd. Rockville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-6-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>6-5/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6386

CERTIFICATE OF DEATH

06370

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 28 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.		d. STREET ADDRESS 12800 Poplar St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Eliza Last Price		4. DATE OF DEATH Month June Day 4 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/84
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbert Pierce		14. MOTHER'S MAIDEN NAME Alice Ann Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart failure DUE TO (c) Hypertensive cardiac vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 wks. 2 yrs 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1953 to June 4, 1956 , that I last saw the deceased alive on June 4, 1956 , and that death occurred at 8:08 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A. D. Bonifant, M. D. Sandy Spring, Md 6/4/56			
ACTUAL SIGNATURE A. D. Bonifant		PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1956	
22c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery		22d. LOCATION (City, town, or county) (State) Colesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Miller		24a. REC'D BY REGISTRAR 6-6-56	
ADDRESS 254 Carroll St. N.W. Takoma Park, D.C.		24b. REGISTRAR'S SIGNATURE Bertrude B. Fowler	

A34
BP

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		DATE OF DEATH 11-11-1956	
TIME OF DEATH 11:00 AM		PLACE OF BIRTH BOSTON, MASS.	
NAME OF DECEASED JOHN J. BROWN		SEX MALE	
AGE 65		RACE WHITE	
STREET ADDRESS 123 MAIN ST.		CITY BOSTON	
STATE MASS.		ZIP CODE 02101	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH 11-11-1956		TIME OF DEATH 11:00 AM	
PLACE OF DEATH HOME		DATE OF DEATH 11-11-1956	
TIME OF DEATH 11:00 AM		PLACE OF BIRTH BOSTON, MASS.	
NAME OF DECEASED JOHN J. BROWN		SEX MALE	
AGE 65		RACE WHITE	
STREET ADDRESS 123 MAIN ST.		CITY BOSTON	
STATE MASS.		ZIP CODE 02101	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	

BUREAU V. 41

11 1956

RECEIVED

6387

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 E. Melrose St.		d. STREET ADDRESS 104 E. Melrose Street.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle M. Last PRINDLE		4. DATE OF DEATH Month June Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1865
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months 9 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Geodetic Survey -- Govt	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. E. J. Clapp-Item # 2	
17. INFORMANT E. J. Clapp-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis, severe DUE TO Senility (b) Chronic bronchitis with severe pulmonary (c) emphysema and Cor pulmonale		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13 , 19 53 to 6-27 , 19 56 , that I last saw the deceased alive on 6-25 , 19 56 , and that death occurred at 12:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Wildman		ADDRESS (Street, city or town, state) 3729 Morrison St. N.W. Washington 15, D.C.	
PHYSICIAN'S NAME (Type) Thomas A. Wildman		DATE SIGNED 6-27-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6/29/1956		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Pine Hill		22d. LOCATION (City, town, or county) (State) Peterborough New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Maryland		24a. REC'D BY REGISTRAR 6-28-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0277

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JOHN J. GOSWELL		1907		BALTIMORE, MARYLAND	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
101 E. BALTIMORE ST.		1956		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		HEART DISEASE		NATURAL	
EDUCATION		SEX		RACE	
HIGH SCHOOL		MALE		WHITE	
RELIGION		TEMPERATURE		PULSE	
METHODIST		98.6		72	
PREVIOUS ILLNESS		BLOOD PRESSURE		WEIGHT	
NONE		120/80		170	
TREATMENT		DIET		SMOKING	
NONE		NONE		NONE	
BURIAL		INTERVIEW		SIGNATURE	
BALTIMORE		NONE		NONE	
DATE OF BURIAL		DATE OF INTERVIEW		DATE OF SIGNATURE	
1956		1956		1956	

BUREAU V. 1

WLT 2 1956

RECEIVED

Robert A. Humphrey - 1537 W. Ave. Beltsville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6388

CERTIFICATE OF DEATH

Reg. Dist. No.

06372
216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland				c. LENGTH OF STAY IN 1b 97 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				d. STREET ADDRESS 5416 Nevada Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Cook Last Richardson		4. DATE OF DEATH Month June Day 5, Year 19 56					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 26, 1906	
				9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Cashier		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Cook				14. MOTHER'S MAIDEN NAME Annie Hollidge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumo-hemo thorax, right. ascertained 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) peritoneal carcinoma and ascites (c) Carcinoma, right and left breasts metastatic to bones. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH one year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 29, 19 56 , to June 5, 19 56 , that I last saw the deceased alive on June 5, 19 56 and that death occurred at 5:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED June 5, 1956 ACTUAL SIGNATURE Bernard Robert Landau M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Bernard Robert Landau, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/8/56		22c. NAME OF CEMETERY OR CREMATORY Landau		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 3072 M St NW		24a. REC'D BY REGISTRAR DATE 6-7-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

9561 11-174

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6298

CERTIFICATE OF DEATH

06373

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>33 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ellis</u> Last <u>Ridgeway</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-4-22</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u>34</u> Days <u>10</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Harry Ridgeway</u>				14. MOTHER'S MAIDEN NAME <u>Lena Herbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) <u>153X</u> DUE TO <u>Intra peritoneal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Rupture Liver - spontaneous</u> DUE TO <u>Metastatic Carcinoma Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 months</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-7</u> , 19 <u>56</u> , to <u>6-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-9</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brawnsberger</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Cornell Ave - Takoma Park - Md</u>			
PHYSICIAN'S NAME (Type) <u>John F. Brawnsberger</u>				DATE SIGNED <u>6-13-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Joseph Sore</u>				ADDRESS <u>4459 Balt Ave Hyattsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>6-13-56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilbur Dodd</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUN 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

CERTIFICATE OF DEATH

Reg. Dist. No.

06374

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Nat'l Inst of Health				d. STREET ADDRESS 119 Raleigh St. S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Faye Middle Ann Last Roberts				4. DATE OF DEATH Month June Day 23 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1951	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		IF UNDER 24 HRS. Months 4 Days 4 Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gerald A. Roberts				14. MOTHER'S MAIDEN NAME Jeanne A. Preil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT The medical record, The Clinical Center	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA and SUPPURATIVE BRONCHITIS 587.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CYSTIC FIBROSIS OF THE PANCREAS (c) SINCE BIRTH				INTERVAL BETWEEN ONSET AND DEATH 1-2 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) June 14, 19 56, to June 23, 19 56				(County) (State)			
21. I certify that I attended the deceased from June 23, 19 56 , that I last saw the deceased alive on June 23, 19 56 , and that death occurred at 5:33 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Christopher M. Martin, M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda, Maryland			
PHYSICIAN'S NAME (Type) Christopher M. Martin, M.D.				DATE SIGNED June 25 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-56		22c. NAME OF CEMETERY OR CREMATORY Washington Natl		22d. LOCATION (City, town, or county) (State) Switzland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.				ADDRESS 1661-16th St NE Wash DC		24a. REC'D BY REGISTRAR DATE JUN 25 1956	
				24b. REGISTRAR'S SIGNATURE Mary Favelly			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JENNIE A. JOHNSON		2. SEX F		3. AGE 68		4. DATE OF BIRTH JAN 15 1887	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION HOUSEWIFE		7. CAUSE OF DEATH HEART DISEASE		8. PLACE OF DEATH HOME	
9. DATE OF DEATH JUN 25 1950		10. TIME OF DEATH 10:30 AM		11. SIGNATURE OF PHYSICIAN J. A. JOHNSON		12. SIGNATURE OF REGISTRAR J. A. JOHNSON	
13. NAME OF FUNERAL HOME THE JOHNSON FUNERAL HOME		14. ADDRESS OF FUNERAL HOME 1234 BALTIMORE ST.		15. CITY BALTIMORE		16. STATE MARYLAND	
17. NAME OF NEXT OF KIN J. A. JOHNSON		18. ADDRESS OF NEXT OF KIN 1234 BALTIMORE ST.		19. CITY BALTIMORE		20. STATE MARYLAND	
21. NAME OF WITNESS J. A. JOHNSON		22. ADDRESS OF WITNESS 1234 BALTIMORE ST.		23. CITY BALTIMORE		24. STATE MARYLAND	
25. NAME OF WITNESS J. A. JOHNSON		26. ADDRESS OF WITNESS 1234 BALTIMORE ST.		27. CITY BALTIMORE		28. STATE MARYLAND	
29. NAME OF WITNESS J. A. JOHNSON		30. ADDRESS OF WITNESS 1234 BALTIMORE ST.		31. CITY BALTIMORE		32. STATE MARYLAND	
33. NAME OF WITNESS J. A. JOHNSON		34. ADDRESS OF WITNESS 1234 BALTIMORE ST.		35. CITY BALTIMORE		36. STATE MARYLAND	
37. NAME OF WITNESS J. A. JOHNSON		38. ADDRESS OF WITNESS 1234 BALTIMORE ST.		39. CITY BALTIMORE		40. STATE MARYLAND	
41. NAME OF WITNESS J. A. JOHNSON		42. ADDRESS OF WITNESS 1234 BALTIMORE ST.		43. CITY BALTIMORE		44. STATE MARYLAND	
45. NAME OF WITNESS J. A. JOHNSON		46. ADDRESS OF WITNESS 1234 BALTIMORE ST.		47. CITY BALTIMORE		48. STATE MARYLAND	
49. NAME OF WITNESS J. A. JOHNSON		50. ADDRESS OF WITNESS 1234 BALTIMORE ST.		51. CITY BALTIMORE		52. STATE MARYLAND	
53. NAME OF WITNESS J. A. JOHNSON		54. ADDRESS OF WITNESS 1234 BALTIMORE ST.		55. CITY BALTIMORE		56. STATE MARYLAND	
57. NAME OF WITNESS J. A. JOHNSON		58. ADDRESS OF WITNESS 1234 BALTIMORE ST.		59. CITY BALTIMORE		60. STATE MARYLAND	
61. NAME OF WITNESS J. A. JOHNSON		62. ADDRESS OF WITNESS 1234 BALTIMORE ST.		63. CITY BALTIMORE		64. STATE MARYLAND	
65. NAME OF WITNESS J. A. JOHNSON		66. ADDRESS OF WITNESS 1234 BALTIMORE ST.		67. CITY BALTIMORE		68. STATE MARYLAND	
69. NAME OF WITNESS J. A. JOHNSON		70. ADDRESS OF WITNESS 1234 BALTIMORE ST.		71. CITY BALTIMORE		72. STATE MARYLAND	
73. NAME OF WITNESS J. A. JOHNSON		74. ADDRESS OF WITNESS 1234 BALTIMORE ST.		75. CITY BALTIMORE		76. STATE MARYLAND	
77. NAME OF WITNESS J. A. JOHNSON		78. ADDRESS OF WITNESS 1234 BALTIMORE ST.		79. CITY BALTIMORE		80. STATE MARYLAND	
81. NAME OF WITNESS J. A. JOHNSON		82. ADDRESS OF WITNESS 1234 BALTIMORE ST.		83. CITY BALTIMORE		84. STATE MARYLAND	
85. NAME OF WITNESS J. A. JOHNSON		86. ADDRESS OF WITNESS 1234 BALTIMORE ST.		87. CITY BALTIMORE		88. STATE MARYLAND	
89. NAME OF WITNESS J. A. JOHNSON		90. ADDRESS OF WITNESS 1234 BALTIMORE ST.		91. CITY BALTIMORE		92. STATE MARYLAND	
93. NAME OF WITNESS J. A. JOHNSON		94. ADDRESS OF WITNESS 1234 BALTIMORE ST.		95. CITY BALTIMORE		96. STATE MARYLAND	
97. NAME OF WITNESS J. A. JOHNSON		98. ADDRESS OF WITNESS 1234 BALTIMORE ST.		99. CITY BALTIMORE		100. STATE MARYLAND	

RECEIVED
JUN 25 1950
BUREAU V. 1

6390

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>5102 Manning Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>C</u> Last <u>Rollins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1875</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unobtainable</u>		14. MOTHER'S MAIDEN NAME <u>unobtainable</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Harry B. Rollins</u>		Address <u>Bethesda, Md. 5102 Manning Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE 2 YRS.</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED 5 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 JUNE, 1956</u> , to <u>20 JUNE 1956</u> , that I last saw the deceased alive on <u>20 JUNE, 1956</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D.		ADDRESS (Street, city or town, state) <u>929 PERSHING DRIVE SILVER SPRING</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		DATE SIGNED <u>20 JUNE 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Forward to the State Registrar, Baltimore, Md. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)
SM 9/55

6391 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06376

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>47x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS HOME</u>		d. STREET ADDRESS <u>3238 Rodman NW</u>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>WALKER</u> Last <u>RUHL</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1861</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Walker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mary L. Ruhl</u>		Address <u>3238 Rodman NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deaf</u> DUE TO <u>Smility (yr. old) Blindness</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Time</u> <u>yr.</u> <u>yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Samuel Allen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>X</u>	
22a. BURIAL (CREMATION) REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 5, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 Bacon NW</u>	
24a. REC'D BY REGISTRAR <u>6/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 7 1956

RECEIVED

Reg. Dist. No. 223

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Inn & Hosp.</u>		d. STREET ADDRESS <u>7512 Jackson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anthony, Jr.</u> Middle <u>A.</u> Last <u>Scaletta</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-92</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Werner Bros.</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Angelo Scaletta</u>	
14. MOTHER'S MAIDEN NAME <u>Anna J. Campagna</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-10-5424</u>		17. INFORMANT <u>Mrs. Agnes Sarah Scaletta</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Angina Pectoris</u> DUE TO (c) <u>Cardio-Vascular Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 hrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26, 1956</u> to <u>June 26, 1956</u> , that I last saw the deceased alive on <u>June 26, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		DATE SIGNED <u>6/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		(Signed with Coroner's Seal)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>
22d. LOCATION (City, town, or county) (State) <u>Montgomery, Md.</u>		22e. REC'D BY REGISTRAR <u>J. Wilson</u>	
22f. REGISTRAR'S SIGNATURE <u>J. Wilson</u>		22g. DATE <u>6/27/56</u>	

VS A15 (4)
15M 9/55

JUN 29 1956

RECEIVED

6300

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>47X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Aghes</i> Middle <i>Maria</i> Last <i>Schneider</i>		4. DATE OF DEATH Month <i>June</i> Day <i>23</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-15-1889</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Minn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>190-10-10000</i>	
17. INFORMANT <i>Intelligence M Reeves</i> Address <i>521 Fern Pl NW Wash DC</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X Congenital Cystic Degeneration</i> DUE TO (b) <i>Congenital Glycystic Liver</i> DUE TO (c) <i>Metastatic Carcinoma Liver Breast 7 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Uremia</i> <i>Heart Failure</i> (b) <i>terminal</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Decubitus Left Colon</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1</i> 19 <i>49</i> , to <i>June 23</i> 19 <i>56</i> , that I last saw the deceased alive on <i>June 23</i> 19 <i>56</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert H. Anglin M.D.</i>		ADDRESS (Street, city or town, state) <i>934 Ellsworth St. Washington D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Herbert H. Anglin</i>		DATE SIGNED <i>6-23-56</i>	
22a. BURIAL (CREMATION, REMOVAL) (Specify) <i>cremation</i>		22b. DATE THEREOF <i>6-25-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Desl Funeral Home</i>		ADDRESS <i>4812 Ka Ave</i>	
24a. REC'D BY REGISTRAR <i>J. H. H. H.</i>		24b. REGISTRAR'S SIGNATURE <i>J. H. H. H.</i>	
DATE <i>6/25/56</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF NOTARY		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF	
21. SIGNATURE OF JAILER		22. SIGNATURE OF WARDEN		23. SIGNATURE OF CHIEF CLERK		24. SIGNATURE OF ASSISTANT CLERK	
25. SIGNATURE OF DEPUTY CLERK		26. SIGNATURE OF JAILER		27. SIGNATURE OF WARDEN		28. SIGNATURE OF CHIEF CLERK	
29. SIGNATURE OF ASSISTANT CLERK		30. SIGNATURE OF JAILER		31. SIGNATURE OF WARDEN		32. SIGNATURE OF CHIEF CLERK	
33. SIGNATURE OF ASSISTANT CLERK		34. SIGNATURE OF JAILER		35. SIGNATURE OF WARDEN		36. SIGNATURE OF CHIEF CLERK	
37. SIGNATURE OF ASSISTANT CLERK		38. SIGNATURE OF JAILER		39. SIGNATURE OF WARDEN		40. SIGNATURE OF CHIEF CLERK	
41. SIGNATURE OF ASSISTANT CLERK		42. SIGNATURE OF JAILER		43. SIGNATURE OF WARDEN		44. SIGNATURE OF CHIEF CLERK	
45. SIGNATURE OF ASSISTANT CLERK		46. SIGNATURE OF JAILER		47. SIGNATURE OF WARDEN		48. SIGNATURE OF CHIEF CLERK	
49. SIGNATURE OF ASSISTANT CLERK		50. SIGNATURE OF JAILER		51. SIGNATURE OF WARDEN		52. SIGNATURE OF CHIEF CLERK	
53. SIGNATURE OF ASSISTANT CLERK		54. SIGNATURE OF JAILER		55. SIGNATURE OF WARDEN		56. SIGNATURE OF CHIEF CLERK	
57. SIGNATURE OF ASSISTANT CLERK		58. SIGNATURE OF JAILER		59. SIGNATURE OF WARDEN		60. SIGNATURE OF CHIEF CLERK	
61. SIGNATURE OF ASSISTANT CLERK		62. SIGNATURE OF JAILER		63. SIGNATURE OF WARDEN		64. SIGNATURE OF CHIEF CLERK	
65. SIGNATURE OF ASSISTANT CLERK		66. SIGNATURE OF JAILER		67. SIGNATURE OF WARDEN		68. SIGNATURE OF CHIEF CLERK	
69. SIGNATURE OF ASSISTANT CLERK		70. SIGNATURE OF JAILER		71. SIGNATURE OF WARDEN		72. SIGNATURE OF CHIEF CLERK	
73. SIGNATURE OF ASSISTANT CLERK		74. SIGNATURE OF JAILER		75. SIGNATURE OF WARDEN		76. SIGNATURE OF CHIEF CLERK	
77. SIGNATURE OF ASSISTANT CLERK		78. SIGNATURE OF JAILER		79. SIGNATURE OF WARDEN		80. SIGNATURE OF CHIEF CLERK	
81. SIGNATURE OF ASSISTANT CLERK		82. SIGNATURE OF JAILER		83. SIGNATURE OF WARDEN		84. SIGNATURE OF CHIEF CLERK	
85. SIGNATURE OF ASSISTANT CLERK		86. SIGNATURE OF JAILER		87. SIGNATURE OF WARDEN		88. SIGNATURE OF CHIEF CLERK	
89. SIGNATURE OF ASSISTANT CLERK		90. SIGNATURE OF JAILER		91. SIGNATURE OF WARDEN		92. SIGNATURE OF CHIEF CLERK	
93. SIGNATURE OF ASSISTANT CLERK		94. SIGNATURE OF JAILER		95. SIGNATURE OF WARDEN		96. SIGNATURE OF CHIEF CLERK	
97. SIGNATURE OF ASSISTANT CLERK		98. SIGNATURE OF JAILER		99. SIGNATURE OF WARDEN		100. SIGNATURE OF CHIEF CLERK	

RECEIVED
JUN 27 1956
BUREAU V. I.

6371

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
c. LENGTH OF STAY in 1b 135 YRS				d. STREET ADDRESS 7305 WILLOW AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7305 WILLOW AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OLIVE BEAUBIEN SCOTT				4. DATE OF DEATH JUNE 20 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 15, 1884	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ILL.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OLIVER BEAUBIEN				14. MOTHER'S MAIDEN NAME KATIE FAULKNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT GEORGE L. SCOTT Address 7305 WILLOW AVE TAKOMA PARK MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Colon with metastasis to lungs 153X DUE TO metastasis to lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) —							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 JUNE 1956 to 20 JUNE 1956 , that I last saw the deceased alive on 19 JUNE 1956 , and that death occurred at 235A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE M. B. Queen				ADDRESS (Street, city or town, state) 7112 Willow Ave TAKOMA PARK MD		DATE SIGNED 20 June 1956	
PHYSICIAN'S NAME (Type) M. B. QUEEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 23 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Ballou ADDRESS 251 CARROLL ST. N.W. WASH. D.C.				24a. RECEIVED BY REGISTRAR 6/21/56		24b. REGISTRAR'S SIGNATURE J. William Ladd	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 22 1956

RECEIVED

6392

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>300 Dogwood Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lee Hollinger Sheaffer</u>		4. DATE OF DEATH <u>June 18 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1888</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office Dept Cumberland Co. Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer McClelland Sheaffer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hollinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Sen. W. T. Sheaffer</u>		Address <u>10,408 Vogel Place Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X massive cerebral infarct, left</u> DUE TO (b) <u>Thrombosis left striate artery</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 wk</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 June 1956</u> to <u>18 June 1956</u> , that I last saw the deceased alive on <u>18 June 1956</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Suburban Hospital Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>L. E. Ash</u>		DATE SIGNED <u>18 June 56</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Karselly</u>	

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6393

CERTIFICATE OF DEATH

06381

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 87 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle H. Last Singleton		4. DATE OF DEATH Month June Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) 68 yrs.
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram Singleton		14. MOTHER'S MAIDEN NAME Maggie Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral infarction, post-140X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) operative blunt & sharp neck dissection DUE TO (c) Carcinoma of lip & neck metastases			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6, 1956 , to June 1, 1956 , that I last saw the deceased alive on June 1, 1956 , and that death occurred at 7:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Austin Milch M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED June 1, 1956	
PHYSICIAN'S NAME (Type) Robert Austin Milch, M.D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 6/2/56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Leeville Cemetery		22d. LOCATION (City, town, or county) (State) Lebanon, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 6-4-56	
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		35		1920		Maryland		Baltimore		Heart Disease		June 15		10:00 AM		Home		[Signature]		[Signature]	



BUREAU V. 2

JUN 5 1956

RECEIVED

Robert A. Humphrey-Bethesda, Md.
Baltimore, Md.
Baltimore, Md.

6322

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>X</i>		d. STREET ADDRESS <i>7717 Greenwood Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Charles Walter SLADE</i>		4. DATE OF DEATH Month <i>6</i> Day <i>-22</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-79</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William R. Slade</i>		14. MOTHER'S MAIDEN NAME <i>Permelia Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-34-4590</i>	
17. INFORMANT <i>Family</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>181X Congestive Cardiac Failure</i> DUE TO (b) <i>Transition</i> DUE TO (c) <i>Carcinoma of Urinary Bladder</i> INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>3 Months</i> <i>18 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-2-</i> , 1956, to <i>6-22-</i> , 1956, that I last saw the deceased alive on <i>6-22-</i> , 1956, and that death occurred at <i>7:40 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7600 Carroll Ave, Takoma Park, Md.</i> DATE SIGNED <i>6/22/56</i>			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		DATE SIGNED <i>6/22/56</i>	
PHYSICIAN'S NAME (Type) <i>Robert H. Hare</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JUNE 25, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>GEORGE WASHINGTON CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>REGGS RD. TR GEO CO Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Hare</i>		24. REC'D BY REGISTRAR <i>J. H. Hare</i>	
ADDRESS <i>TAKOMA PARK 122</i>		25. REGISTRAR'S SIGNATURE <i>J. H. Hare</i>	
DATE <i>6/25/56</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>William A. Smith</i>		AGE <i>65</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1890</i>		PLACE OF BIRTH <i>MD</i>		MARRIAGE <i>Married</i>		OCCUPATION <i>Retired</i>	
RESIDENCE <i>1234 Main St, Baltimore, MD</i>		DATE OF DEATH <i>June 27, 1956</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>	
DATE OF DEATH <i>June 27, 1956</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>		SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. 8

JUN 27 1956

RECEIVED

6394

CERTIFICATE OF DEATH

06383

Reg. Dist. No. 219

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Mont	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1327 Fenwick Lane		d. STREET ADDRESS 1327 Fenwick Lane	
3. NAME OF DECEASED (Type or print) First George Middle Gilbert Last Slentz		4. DATE OF DEATH Month June Day 26 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17, 1899
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Internal Revenue		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Edward Slentz		14. MOTHER'S MAIDEN NAME Emma C. Berkaholtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.# 1 none	
17. INFORMANT daughter		Address Bethesda, Md. Mrs. Constance Strack, 9920 Mayfield Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 45 MIN.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 26 JUNE, 1956 , to 26 JUNE, 1956 , that I last saw the deceased alive on 26 JUNE, 1956 , and that death occurred at 8 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L.B. Snow		DATE SIGNED 6/26/56	
PHYSICIAN'S NAME (Type) Lee B. Snow		ADDRESS (Street, city or town, state) 9013 FLOWER AVE. SILVER SPRING, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/29/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR 630/56	24b. REGISTRAR'S SIGNATURE Frances Collier

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

RECEIVED

JUL 5 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06384

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood, Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5310 Sunset Lane				d. STREET ADDRESS 5310 Sunset Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Middle Jones Last SMITH				4. DATE OF DEATH Month June Day 25 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1906		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 8 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington(state)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Stiles Jones				14. MOTHER'S MAIDEN NAME Adelaide VonKolsterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carleton D. Smith-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of both ovaries with metastases 175X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/27/1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 6-26-56		24b. REGISTRAR'S SIGNATURE <i>Bernard M. Thompson</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, and page 3 should be used as a burial-transit permit. File pages 4 and 5 with the registrar prior to burial, or removal.

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6396

CERTIFICATE OF DEATH

Reg. Dist. No. 274

063854

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boswell Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
f. STREET ADDRESS 506 S. Washington Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Tschiffely Last SMITH				4. DATE OF DEATH Month June Day 22 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1867	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Darnestown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Elgar Tschiffely				14. MOTHER'S MAIDEN NAME Jane Amelia Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Katharine T. Smith-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Longstanding arteriosclerosis DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from March 2, 1956 , to June 22, 1956 , that I last saw the deceased alive on June 23, 1956 , and that death occurred at 4:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John S. Rogers				ADDRESS (Street, city or town, state) 1919 Seminary Rd. Silver Spring, Md.			
PHYSICIAN'S NAME (Type) John S. Rogers, M.D.				DATE SIGNED 6-25-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/1956		22c. NAME OF CEMETERY OR CREMATORY Darnestown		22d. LOCATION (City, town, or county) (State) Darnestown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 6/26/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. L. M. Grey-1957-12-24, Baltimore, Md.
 Bureau of Census
 1957-1958

RECEIVED

JUN 28 1956

BUREAU V. 2

[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through.]

Name		Jane Amelia Rice	
Sex		Female	
Race		White	
Date of Birth		Sept. 27, 1907	
Place of Birth		Baltimore, Maryland, USA	
Marital Status		Single	
Address		308 S. Washington Street Boswell Building, Baltimore	
Occupation		Technician	
Education		High School	
Religion		None	
Signature		<i>[Signature]</i>	
Date		June 28, 1956	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

Reg. Dist. No.

06386

6398

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Arlington</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>6039 21st Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Laura B. SMITH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10 July 1870</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen BRONSON</u>		14. MOTHER'S MAIDEN NAME <u>Catherine BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>John H.B. SMITH, 6039 21st St., N. ARLINGTON, VA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Anger</u> 903.0 DUE TO (b) <u>Fracture @ Hip</u> DUE TO (c) <u>Arteriosclerotic Heart dis. & Congestive failure - yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fall in home trigger was aplasia cere</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Ca 4 days</u> <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home trigger was aplasia cere</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>Jun 19 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town (County) (State) <u>Arlington Arlington Va.</u>	
21. I certify that I attended the deceased from <u>19 June</u> , 1956, to <u>29 June</u> , 1956, that I last saw the deceased alive on <u>29 June</u> , 1956, and that death occurred at <u>8:21 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. C. MURPHY</u>		M.D. <u>USNH, NNMC, Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>C. C. MURPHY, CDR MC USN</u>		<u>USNH, NNMC, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2 Jul 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prince George Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 2 Jul 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

JUL 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131-217

6397

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN Ib 6 days		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood		d. STREET ADDRESS 13X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Ruble Middle Miller Last Smith		4. DATE OF DEATH Month June Day 8 Year 19 56		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/29/21		9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter's helper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME O. P. Smith		14. MOTHER'S MAIDEN NAME Mary Elizabeth Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral hemorrhage and laceration of brain DUE TO (c) 6 days		INTERVAL BETWEEN ONSET AND DEATH 6 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which left highway.		20c. TIME OF INJURY Month, Day, Year 5:50 p.m. 6/2/56		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Burntwood Rd		20f. (City or town) Glenwood (County) Howard (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE F. J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/8/56		22a. BURIAL CREMATION Burial		22b. DATE THEREOF 6/12/56		22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		22d. LOCATION (City, town, or county) Rogersville, Tenn. (State) Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Clive		ADDRESS Frederick Md		24a. REC'D BY REGISTRAR 9 June 1956		24b. REGISTRAR'S SIGNATURE Ely J. H. H. H.		24c. Gertrude L. L. L.											

MISSOURI STATE DEPARTMENT OF HEALTH - BOSTON, MO. 64
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

131

BUREAU V. S.

JUN 11 1956

RECEIVED

James H. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06388

6399

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Louis</u> Last <u>STAFFORD</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Aug. 1899</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Stafford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-1&2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Kathleen Stafford (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>11 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 June</u> , 19 <u>56</u> , to <u>10 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 June</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Dominic A. Brancazio</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>6-11-56</u>			
ACTUAL SIGNATURE <u>Dominic A. Brancazio</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dominic A. Brancazio, LT, MC, USNR</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>		24. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	
25. ADDRESS <u>Bethesda, Maryland</u>		26. REC'D BY REGISTRAR <u>6-11-56</u>	

RECEIVED

BUREAU V. 3

1956 2461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6400

CERTIFICATE OF DEATH

06389

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET Estelle TAVENNER</u>		4. DATE OF DEATH Month Day Year <u>6 - 4 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898 12-13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel F. West</u>		14. MOTHER'S MAIDEN NAME <u>Jennie E. Loftus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>4121 Warner St Kensington, Md.</u>	
17. INFORMANT <u>Richard TAVENNER - Son</u>		Address <u>4121 Warner St Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Central Angina</u> DUE TO (b) <u>Central Hemorrhage</u> DUE TO (c) <u>Hypertensive C-v disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>48 hrs</u> <u>Indef</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/30/56</u> , 19 <u>56</u> , to <u>6/4/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/4/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen D. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md</u> DATE SIGNED <u>6/4/56</u>	
PHYSICIAN'S NAME (Type) <u>Stephen D. Jones</u>		<u>Rockville Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-7-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>6/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. 3

GET 2 NOV

RECEIVED

6401

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mathew Middle Thompson Last Thompson		4. DATE OF DEATH Month June Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown approx 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT Address Hospital Record	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arteriosclerosis DUE TO (b) Bilateral thrombophlebitis both lower limbs DUE TO (c) Septicemia CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) a			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11/56 , to 6/24/56 , that I last saw the deceased alive on 6/22/56 , and that death occurred at 12:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M.D.		DATE SIGNED 6/25/56	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/56	
22c. NAME OF CEMETERY OR CREMATORY Sandy Spring		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Shumaker		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR 6-30-56		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*
AGE: *45*
SEX: *Male*
DATE OF BIRTH: *Jan 15, 1910*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *July 10, 1956*
PLACE OF DEATH: *Home*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF WITNESS: *[Signature]*
DATE: *July 10, 1956*

RECEIVED
JUL 6 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06391

6402

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Nevada b. COUNTY 65X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carson City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS P. O. Box 399			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alonzo Middle Graves Last Tirrell				4. DATE OF DEATH Month June Day 20 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker				10b. KIND OF BUSINESS OR INDUSTRY State Highway Dept.		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Tirrell				14. MOTHER'S MAIDEN NAME Eliza Graves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II				16. SOCIAL SECURITY NO. 025-14-3913		17. INFORMANT Address The Medical Record The Clinical Center Bethesda 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor of the brain (metastatic) 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) seminoma of the testis, extensive DUE TO (c) metastatic							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 2, 1956 , to June 20, 1956 , that I last saw the deceased alive on June 20, 1956 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6/20/56 DATE SIGNED							
ACTUAL SIGNATURE Mehran Goulian M.D. The Clinical Center, The National Institutes of Health, Bethesda, Maryland							
PHYSICIAN'S NAME (Type) Mehran Goulian, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md		24a. REC'D BY REGISTRAR DATE 6-23-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6493
CERTIFICATE OF DEATH

06392

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 518 12th St, N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle AV Last TODD		4. DATE OF DEATH Month June Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7 1956
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Malvin Edward TODD		14. MOTHER'S MAIDEN NAME Gloria EDWARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Malvin E. TODD (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2hr. 17 min.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 June , 19 56 , to 7 June , 19 56 , that I last saw the deceased alive on 7 June , 19 56 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L Baird		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-7-56	
PHYSICIAN'S NAME (Type) Robert L. BAIRD, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Malvin & Shey		ADDRESS 424 "R" St., N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE 6-7-56		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6404

CERTIFICATE OF DEATH

06393

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 hr. 17 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy "B" Middle TODD Last TODD		4. DATE OF DEATH Month June Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 June 1956
9. AGE (In years last birthday) yrs. 29		IF UNDER 1 YEAR Months 2 Days 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Malvin Edward TODD		14. MOTHER'S MAIDEN NAME Gloria EDWARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Malvin E. TODD (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 2 hr. 29 min.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 June 1956 , to 7 June 1956 , that I last saw the deceased alive on 7 June 1956 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L. Baird		DATE SIGNED 6-7-56	
PHYSICIAN'S NAME (Type) Robert L. BAIRD, LT, MC, USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Shey		24a. REC'D BY REGISTRAR DATE 7-6-56	
ADDRESS Malvan & Shey, 424 "R" St., N.W. Washington, DC		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

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CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Grafton Street</u>				d. STREET ADDRESS <u>110 Grafton Street</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE P. TOWNSEND</u>				4. DATE OF DEATH <u>June 23, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Mar. 15, 1856</u>		9. AGE (In years last birthday) yrs. <u>100</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>Robert Swan</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Thackster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dorothy B. Townsend-Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 23, 1956</u> to <u>June 27, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Harell</u> M.D.				ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Harell MD.</u>				DATE SIGNED <u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6426

CERTIFICATE OF DEATH

Reg. Dist. No.

063956

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>Kensington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>STATE</u> <u>215 P St. N.E.</u> <u>Wash. D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>17 mo.</u>		d. STREET ADDRESS <u>10231 Connell Pl.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>A.</u> Last <u>TULL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 1865</u>
9. AGE (In years, months, and days) <u>90</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>For Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elie Peter Ashbrook</u>		14. MOTHER'S M maiden NAME <u>Mary Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. H.W. Moore</u>		Address <u>726 Hilltop Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4443X</u> <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11</u> , 19 <u>54</u> to <u>6-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-1</u> , 19 <u>56</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Bowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. BOWDEN</u>		DATE SIGNED <u>CHEVY CHASE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE HEREOF <u>6/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium - Wash. D.C.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Wash</u>		ADDRESS <u>DATE</u>	
24a. REC'D BY REGISTRAR <u>6-5</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John William Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1911</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md.</i>	
DATE OF DEATH <i>June 10 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md.</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		CERTIFICATE NO. <i>12345</i>		REGISTRATION NO. <i>67890</i>	
SIGNATURE OF DECEASED <i>John W. Smith</i>		SIGNATURE OF NEXT OF KIN <i>John W. Smith</i>		SIGNATURE OF PHYSICIAN <i>John W. Smith</i>		SIGNATURE OF CLERK <i>John W. Smith</i>		SIGNATURE OF REGISTRAR <i>John W. Smith</i>		SIGNATURE OF JUDGE <i>John W. Smith</i>		SIGNATURE OF SHERIFF <i>John W. Smith</i>		SIGNATURE OF CORONER <i>John W. Smith</i>		SIGNATURE OF DEPUTY <i>John W. Smith</i>	
DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>		DATE OF SIGNATURE <i>June 10 1956</i>	

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6497

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 16 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,220 COLESVILLE ROAD				d. STREET ADDRESS 10,220 Colesville Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MABEL Middle VIRGINIA Last TURNER				4. DATE OF DEATH Month JUNE Day 8 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/84	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME RICHARD GODDARD				14. MOTHER'S MAIDEN NAME JENNIE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Mary S. Turner, 10,220 Colesville Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1940 to 8 June, 1956 , that I last saw the deceased alive on 7 June, 1956 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D. 9006 Colesville Rd, Silver Spr. 8 June 56				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) WILLIAM D. AUD				9006 Colesville Road, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/56		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 6/11/56		24b. REGISTRAR'S SIGNATURE Francis C. Carter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6303

CERTIFICATE OF DEATH

06397

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Island</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>211 Newbridge Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Charles</u> Last <u>Valentine</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>11</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Driving Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Valentine</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Terhan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W. I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington Sanitarium Hospital Records, Takoma Park</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute uremia</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Nephrosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1956</u> to <u>June 9, 1956</u> , that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Canale Ave, Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		DATE SIGNED <u>June 9/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 14, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTBURY, L. I. N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Allen</u>		ADDRESS <u>354 Canale Ave, Takoma Park, D. C.</u>	
24a. REC'D BY REGISTRAR <u>6/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Terhan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 & 9 : G202 8/31/56 dmr. **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery 6307 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 844 Rockville Pike		d. STREET ADDRESS 844 Rockville Pike	
3. NAME OF DECEASED (Type or print) CHARLES First VIETT Middle Last		4. DATE OF DEATH June 25, 19 56 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871 Jne 2, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR 0 Months 23 Days 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Builder		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry Viett		14. MOTHER'S MAIDEN NAME Helen Lau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Address	
16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years 5 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 , to June 25, 1956 ; that I last saw the deceased alive on June 25, 1956 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED June 25/56 ACTUAL SIGNATURE Wm A. Lintner M.D. PHYSICIAN'S NAME (Type) Wm A. Lintner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-56	22c. NAME OF CEMETERY OR CREMATORY Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 6/28/56	24b. REGISTRAR'S SIGNATURE Dwight Kragtop

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		Male		35		Jan 5, 1928		Jackson, Mississippi	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
April 4, 1968		Memphis, Tennessee		Shot		Suicide		Attorney	
TIME OF DEATH		HOURS		MINUTES		SECOND		P.M.	
10:00		4		15		00		P	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		RELATIONSHIP		SIGNATURE	
April 5, 1968		Memphis, Tennessee		JAMES EARL RAY		Son		[Signature]	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		RELATIONSHIP		SIGNATURE	
April 5, 1968		Memphis, Tennessee		JAMES EARL RAY		Son		[Signature]	
DATE OF CORONER'S REPORT		PLACE OF CORONER'S REPORT		CORONER'S REPORT BY		RELATIONSHIP		SIGNATURE	
April 5, 1968		Memphis, Tennessee		JAMES EARL RAY		Son		[Signature]	
DATE OF MEDICAL EXAMINATION		PLACE OF MEDICAL EXAMINATION		MEDICAL EXAMINATION BY		RELATIONSHIP		SIGNATURE	
April 5, 1968		Memphis, Tennessee		JAMES EARL RAY		Son		[Signature]	
DATE OF BURIAL		PLACE OF BURIAL		BURIAL BY		RELATIONSHIP		SIGNATURE	
April 5, 1968		Memphis, Tennessee		JAMES EARL RAY		Son		[Signature]	

BUREAU V. S.

JUN 29 1968

RECEIVED

6324

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>WATSON</u> Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/56</u>
9. AGE (In years last birthday) yrs. <u>16</u> Min. <u>20</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES Roberson Junior</u>		14. MOTHER'S MAIDEN NAME <u>Mary RUTH WATSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mary RUTH WATSON</u> Address <u>8625 Piney Br. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-6</u> , 19 <u>56</u> , to <u>6-7</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>6-7</u> , 19 <u>56</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold Sterling</u>		ADDRESS (Street, city or town, state) <u>2100 Connecticut Avenue, N.W., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Harold Sterling</u>		DATE SIGNED <u>6-10-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-11-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hare</u> ADDRESS <u>Washington Sanitarium and Hospital, T.P., Md.</u>		24. REC'D BY REGISTRAR <u>JUN 13 1956</u> 25. REGISTRAR'S SIGNATURE <u>Robert Hare</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FORM

1. NAME OF DECEASED <i>James E. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 18 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>USA</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF WITNESS <i>[Signature]</i>		18. SIGNATURE OF REGISTRAR <i>[Signature]</i>	

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within 72 hours after death.

VS A15 (4)
15M 9/55 A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6498

CERTIFICATE OF DEATH

06400

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>2230 California St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Amelia</u> Last <u>Woodward</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>George H. Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Claude H. Woodward</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>20 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>39</u> , to <u>June 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>39</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Gilbert B. Rude</u> M.D. <u>7700 Glenbrooke Rd., Chevy Chase, Md.</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <u>Gilbert B. Rude</u>							
22a. BURIAL <input checked="" type="checkbox"/> REMOVAL <input type="checkbox"/>		22b. DATE THEREOF <u>6/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Ames Co.</u> ADDRESS <u>2801-15 St. N.W.</u>				24a. REC'D BY REGISTRAR <u>6/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

BUREAU

JUN 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

CERTIFICATE OF DEATH

06401

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>10557 Metropolitan</u>	
3. NAME OF DECEASED (Type or print) First <u>Adeline</u> Middle <u>E. Woodwell</u> Last <u>June</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey H. Brainerd</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Alden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Lawrence A. Woodwell</u>		Address <u>2034 Milton St. Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple myocardial infarction</u> DUE TO (c) <u>coronary sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days and also 3 mos</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-5</u> , 195 <u>6</u> , to <u>6-6</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>6-5</u> , 195 <u>6</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash 15 DC</u> DATE SIGNED <u>6/6/56</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. N.W. Wash 15 DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-7-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>6/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Harrison</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 10, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PRESENT ADDRESS <i>123 Main St., Baltimore, Md.</i>		14. DATE OF BIRTH <i>June 10, 1911</i>		15. PLACE OF BIRTH <i>Baltimore, Md.</i>	
16. NAME OF PHYSICIAN <i>Dr. J. K. Smith</i>		17. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		18. NAME OF NURSE <i>Miss M. Jones</i>	
19. NAME OF CORONER <i>John Doe</i>		20. NAME OF JURY <i>John Doe, J. K. Smith, J. L. Brown</i>		21. NAME OF WITNESSES <i>John Doe, J. K. Smith</i>	
22. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>		23. NAME OF FUNERAL HOME <i>St. Mary's Funeral Home</i>		24. NAME OF MINISTER <i>Rev. J. K. Smith</i>	
25. NAME OF CLERGYMAN <i>Rev. J. K. Smith</i>		26. NAME OF CHURCH <i>St. Mary's Church</i>		27. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
28. NAME OF INTERMENT <i>St. Mary's Cemetery</i>		29. NAME OF INTERMENT <i>St. Mary's Cemetery</i>		30. NAME OF INTERMENT <i>St. Mary's Cemetery</i>	

1

BUREAU V

JUN 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 210

06402

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE D.C. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) William Yee		f. STREET ADDRESS 1817 Adams Mill Rd. N.W.	
4. DATE OF DEATH June 17 19 56		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/29
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY City bank	
11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Yee Lou Woh		14. MOTHER'S MAIDEN NAME Unknown Mow Soe Hien	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Drivers license		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Swimming in Glen Echo pool 5 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming Glen Echo Montg Md.	
20c. TIME OF INJURY Month, Day, Year 4:50 P.M. 6/17 56	20d. INJURY OCCURRED pool Glen Echo Montg Md.	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6-17-56	
22c. NAME OF CEMETERY OR CREMATORY LEE's FUNERAL HOME		22d. LOCATION (City, town, or county) (State) 4th & Mass Ave. N.E. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24. REC'D BY REGISTRAR Benie M. Thompson	
ADDRESS 7557 Wisconsin Ave		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, making the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 20 1956

RECEIVED

6411

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Bethesda</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5821 Goldsboro Rd.</i>				STREET ADDRESS (If rural give location) <i>5821 Goldsboro Rd.</i>			
3. NAME OF DECEASED: (Type or Print) <i>ELSIE</i>		(First) <i>D</i>		(Middle) <i>YOUNG</i>		(Last)	
4. DATE OF DEATH: <i>June 14 1956</i>		(Month) (Day) (Year)					
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH: <i>Feb. 8, 1873</i>	9. AGE last birthday: <i>83</i> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>GUNNEL</i>				14. MOTHER'S MAIDEN NAME: <i>HOGAN CAMP</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>(If Yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT & ADDRESS: <i>J.J. Hadley 5821 Goldsboro Rd.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>						<i>48 hrs</i>	
ANTECEDENT CAUSE (S): (B) <i>Carcinoma of the Bladder</i>						<i>3 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>April 1953</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of Bladder</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1, 1950</i> to <i>June 4, 1956</i> that I last saw the deceased alive on <i>June 14, 1956</i> and that death occurred at <i>2:15</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>Horace H. Custer Jr.</i>		M. D. <i>Washington</i>		DATE SIGNED <i>6/14/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 16/56</i>		NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cem.</i>		LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 15-1956</i>		REGISTRAR'S SIGNATURE <i>Bennie M. Thompson</i>		24. FUNERAL DIRECTOR <i>The R. H. Niles & Co.</i>		ADDRESS <i>2901-14th St. N.W. Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 19 1956

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